

## 7395 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>WEST VIRGINIA</b> b. COUNTY <b>MINERAL</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WILEY FORD</b>			
c. LENGTH OF STAY IN 1b <b>14 DAYS</b>				d. STREET ADDRESS <b>HIGHLAND AVENUE</b>			
d. NAME OF HOSPITAL (If not in hospital, write name of institution) <b>WEST VIRGINIA MEMORIAL HOSPITAL AVE.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Ilario (LARRY) ALVARO</b>				4. DATE OF DEATH Month Day Year <b>JULY 5 19 59</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>AUGUST 12, 1899</b>	
9. AGE (In years last birthday) <b>59</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>yard clerk</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>B&amp;O R.R.</b>		11. BIRTHPLACE (State or foreign country) <b>ITALY</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>JAMES ALVARO</b>				14. MOTHER'S MAIDEN NAME <b>Anglia Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>705-05-8045</b>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <b>14 minutes</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>June</b> , 19 <b>59</b> to <b>July</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>June 5</b> , 19 <b>59</b> , and that death occurred at <b>6:30 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>[Signature]</b>				M.D. <b>133 Va Ave</b>			
PHYSICIAN'S NAME (Type) <b>DR. OVERTON, HIMMELWRIGHT</b>				DATE SIGNED <b>7/7/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-9-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b> ADDRESS <b>108 Va. Ave., CumB.</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 10 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WEST VIRGINIA

WEST VIRGINIA

WEST VIRGINIA

WILLY TOLSON

14 DAYS

WEST VIRGINIA

WARREN & MEMORIAL

WEST VIRGINIA

HIGHWAY AVENUE

AGE

WEST VIRGINIA

PLAT

ALWAYS

LIBRARY

WHITE

AUGUST 12, 1900

WILLY

W. E.

WEST VIRGINIA

WEST VIRGINIA

WEST VIRGINIA

*W. E. Willy*

DR. GUSTON HINGSTON

7396

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>18 HRS.</b>			
d. NAME OF HOSPITAL (If in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVES.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>DIANE</b> Middle <b>LYNNE</b> Last <b>ATHEY</b>				4. DATE OF DEATH Month <b>JULY</b> Day <b>14</b> Year <b>1959</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JULY 13, 1959</b>	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>CUMBERLAND, MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>?</b>				14. MOTHER'S MAIDEN NAME <b>SHIRLEY J. ATHEY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>none</b>			
17. INFORMANT <b>MEMORIAL HOSPITAL</b>				Address <b>CUMBERLAND, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity 28-30 wks</b> 776x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>13 July, 1959</b> to <b>14 July, 1959</b> , that I last saw the deceased alive on <b>14 July, 1959</b> , and that death occurred at <b>12:14 PM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Cumberland Md</b> DATE SIGNED <b>15 July 59</b>							
ACTUAL SIGNATURE <b>Julius B. Whitworth</b>				PHYSICIAN'S NAME (Type) <b>F. B. WHITWORTH</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 15, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 16 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton S. Kraus</b>	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2060201XV2

CERTIFICATE OF DEATH

1933

ALLIANCE

ALLIANCE

SUBSIDIARY

SUBSIDIARY

10 H.T.

GENERAL HOSPITAL

GENERAL & MEDICAL DEPT.

1000 LINDEN AVE.

WHITE

WHITE

WHITE

CHIEF OF CLINIC

100

T. C. WHITE

7397

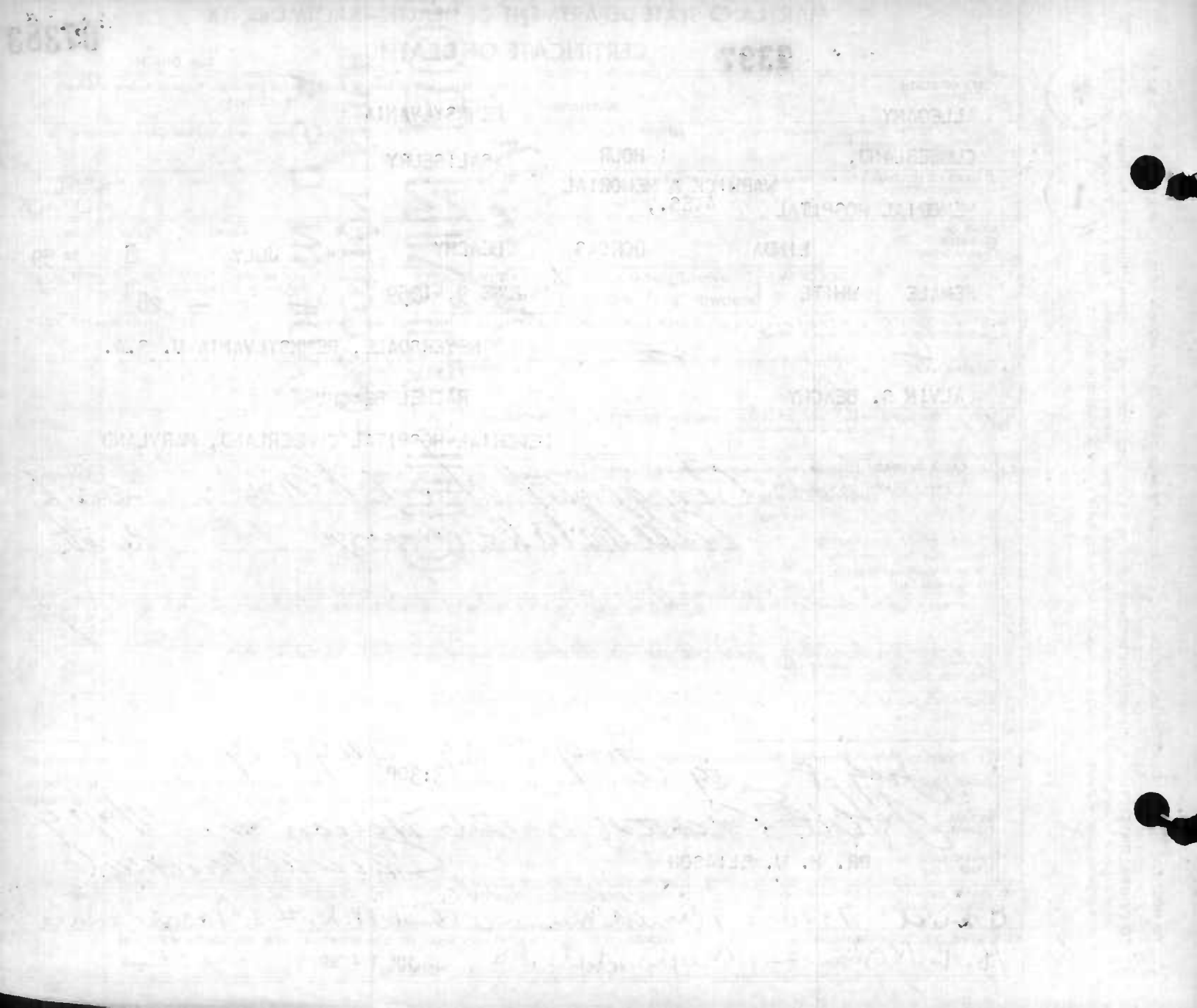
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>PENNSYLVANIA</b> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND,</b>			c. LENGTH OF STAY IN 1b <b>1 HOUR</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WARWICK &amp; MEMORIAL MEMORIAL HOSPITAL AVES.,</b>			d. STREET ADDRESS		
3. NAME OF DECEASED (Type or print) First <b>LINDA</b> Middle <b>DORCAS</b> Last <b>BEACHY</b>			4. DATE OF DEATH Month <b>JULY</b> Day <b>8</b> Year <b>19 59</b>		
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 9, 1959</b>		9. AGE (In years lost birthday) yrs. <b>28</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>L</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>L</b>		11. BIRTHPLACE (State or foreign country) <b>MEYERSDALE, PENNSYLVANIA U. S.A.</b>
13. FATHER'S NAME <b>ALVIN S. BEACHY</b>			14. MOTHER'S MAIDEN NAME <b>RACHEL BEACHY</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>MEMORIAL HOSPITAL CUMBERLAND, MARYLAND</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>754.5</b> <b>Con genital Heart Lesion</b> DUE TO <b>Atelectatic Lung.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Burial</b> DUE TO (c) <b>Burial</b>					INTERVAL BETWEEN ONSET AND DEATH <b>Burial</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Aug. 8, 1959</b> to <b>Aug 8, 1959</b> , that I last saw the deceased alive on <b>Aug 8, 1959</b> , and that death occurred at <b>3:30 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>126 Union St. Cumberland</b> DATE SIGNED <b>7/9/59</b>					
ACTUAL SIGNATURE <b>DR. H. W. ELIASON</b>			PHYSICIAN'S NAME (Type) <b>DR. H. W. ELIASON</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-10-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Amish Mennonite Church P. D. # 3, Meyersdale, Pa.</b>		22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. P. Konhaus, Meyersdale, Pa.</b>			24a. REC'D BY REGISTRAR DATE <b>JUL 14 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Orlando S. Knaus</b>

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained in the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## 7457 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07381

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Little Orleans Md.</b>		c. LENGTH OF STAY IN 1b <b>5 Yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Little Orleans Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Home</b>				d. STREET ADDRESS <b>Little Orleans Md.</b>			
3. NAME OF DECEASED (Type or print) First <b>Arthur</b> Middle <b>Alan</b> Last <b>Beatty</b>				4. DATE OF DEATH Month <b>7</b> Day <b>4</b> Year <b>19 59</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8.1.1895</b>		9. AGE (In years last birthday) <b>63</b> yrs.	IF UNDER 1 YEAR Months <b>11</b> Days <b>3</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Labor</b>		11. BIRTHPLACE (State or foreign country) <b>Fulton County Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William C Beatty</b>				14. MOTHER'S MAIDEN NAME <b>Sarah J Ray</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs Marvin Golden Littell Orleans Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO <b>Coronary Artery Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b></b> DUE TO (c) <b></b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b></b>					
20c. TIME OF INJURY Hour <b></b> a. m. <b></b> p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Little Orleans Md</b>		20f. (City or town) (County) (State) <b>Allegany</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <b>[Signature]</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>B. J. Williams</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4.7.59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Buck Valley Christian</b>		22d. LOCATION (City, town, or county) (State) <b>Buck Valley Fulton Penna.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard J. Shaw</b>				ADDRESS <b>Hancock Md</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 9 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





7458

## CERTIFICATE OF DEATH

07384

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RFD 3 Cumberland Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RFD Cumberland Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mill Rd.</u>		d. STREET ADDRESS <u>Mill Road</u>	
3. NAME OF DECEASED (Type or print) <u>Carl Lewis Beck</u>		4. DATE OF DEATH <u>July 27 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 9 1897</u>
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hauling</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Truck Contractor Cumberland</u>	
11. BIRTHPLACE (State or foreign country) <u>M. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Charles Beck</u>		14. MOTHER'S MAIDEN NAME <u>Anna Wolf</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, indicate unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs. Louise Beck</u>		Address <u>Cumb. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO <u>CV Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>27 July 1959</u> , to <u>27 day 1959</u> , that I last saw the deceased alive on <u>19 day 1959</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Carlton Brinsfield</u> M.D.		ADDRESS (Street, city or town, state) <u>232 Baltimore Ave</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>CARLTON BRINSFIELD M.D.</u>		<u>Cumberland Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>7/29/59</u>	<u>Hillcrest Burial</u>	<u>Cumberland Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc.</u>		ADDRESS <u>Cumb. Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>JUL 30 59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoma</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07385

7398

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>28 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sacred Heart Hospital</b>				d. STREET ADDRESS <b>215 Decatur St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Irvin</b> Middle <b>May</b> Last <b>Blackburn</b>				4. DATE OF DEATH Month <b>7</b> Day <b>24</b> Year <b>1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/25/ 1899</b>	
9. AGE (In years last birthday) <b>60</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>W.Va. Spring Gap</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
13. FATHER'S NAME <b>William p. Moreland</b>				14. MOTHER'S MAIDEN NAME <b>Mary Laurgent</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>218-30-0663</b>		17. INFORMANT <b>Patients Chart</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute left ventricular failure</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Myocardial fibrosis; Coronary arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Auricular fibrillation, embolus popliteal artery (L), embolectomy</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 2, 1959</b> , to <b>July 24, 1959</b> , that I lost the deceased on <b>July 24, 1959</b> , and that death occurred at <b>7:35 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>S. M. Jacobson</b> M.D.							
PHYSICIAN'S NAME (Type) <b>S. M. Jacobson, M.D., 50 Pershing Street, Cumberland, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-28-1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Forest Glen Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Greenspring, W. Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 30 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>	

# MARYLAND STATE DEPARTMENT OF HEALTH - CERTIFICATE OF DEATH

1398

DECEASED

NAME

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

RESIDENCE

DATE OF BIRTH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

DIAGNOSIS

TESTS

REMARKS

DATE OF BIRTH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

DIAGNOSIS

TESTS

REMARKS

DATE OF BIRTH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

DIAGNOSIS

TESTS

REMARKS

DATE OF BIRTH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

DIAGNOSIS

TESTS

REMARKS

DATE OF BIRTH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

DIAGNOSIS

TESTS

REMARKS

DATE OF BIRTH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

DIAGNOSIS

TESTS

REMARKS

7459

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>McCoole</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>McCoole</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>16 Queen St.</u>		d. STREET ADDRESS <u>16 Queen St.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Goldie</u> First <u>Lillian</u> Middle <u>Boehmes</u> Last		4. DATE OF DEATH Month <u>July</u> Day <u>12</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 25, 1893</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>17</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Keyser W.Va.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Lahman</u>		14. MOTHER'S MAIDEN NAME <u>Lara Lease</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>235-18-2879</u>	
17. INFORMANT <u>Charles Oliver Boehmes</u> Address <u>McCoole, M.D.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carina Lung Bronchumia</u> <u>162.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sept 1958</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct</u> , 19 <u>58</u> , to <u>July 12</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>July 12 59</u> , 19 <u>59</u> , and that death occurred at <u>7:13</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Keyser W.Va.</u> DATE SIGNED <u>7-13-59</u>			
ACTUAL SIGNATURE <u>T.C. Giffin</u> M.D.		DATE SIGNED <u>7-13-59</u>	
PHYSICIAN'S NAME (Type) <u>T.C. Giffin</u> M.D.		DATE SIGNED <u>7-13-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-15-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Queen's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Keyser W.Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas R. Smith Jr.</u>		ADDRESS <u>Keyser, W.Va.</u>	
24a. REC'D BY REGISTRAR DATE <u>JUL 15 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





7449  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <u>Frostburg</u>		c. LENGTH OF STAY IN 1b <u>2 HRS.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Miners Hospital</u>		d. STREET ADDRESS <u>1116 South Water St</u>	
3. NAME OF DECEASED (Type or print) <u>Arthur Tigaw Bond</u>		4. DATE OF DEATH <u>July 27 1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/26/79</u>
9. AGE (In years lost birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Postal Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Postal Dept</u>	
11. BIRTHPLACE (State or foreign country) <u>Frostburg Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Thomas Bond</u>		14. MOTHER'S MAIDEN NAME <u>Cecilia Appledorn</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs Arthur Bond</u>		Address <u>Frostburg, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u> 420.1 DUE TO: Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Atherosclerosis</u> DUE TO (c) <u>15 yr.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 27, 1959</u> to <u>July 27, 1959</u> , that I last saw the deceased alive on <u>July 27, 1959</u> , and that death occurred at <u>9:00 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Alvin J. Walters</u> M.D.		ADDRESS (Street, city or town, state) <u>48 BROADWAY</u>	
PHYSICIAN'S NAME (Type) <u>Alvin J. Walters</u>		FROSTBURG, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>7-30-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Frostburg Memorial Park</u>	22d. LOCATION (City, town, or county) (State) <u>Frostburg Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Durst</u>		ADDRESS <u>Frostburg, Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE JUL 31 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Alvin J. Walters</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07389

## 7400 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>ALLEGANY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u>				c. LENGTH OF STAY IN 1b <u>26</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SACRED HEART</u>				d. STREET ADDRESS <u>408 Footer Place</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>OWEN</u> Middle <u>Sylvester</u> Last <u>BRANT</u>				4. DATE OF DEATH Month <u>7</u> Day <u>3</u> Year <u>1959</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 23, 1884</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u> Hours <u>1</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>3</u> Days <u>3</u> Hours <u>1</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Ridgeley, W. Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Hiliary Brant</u>				14. MOTHER'S MAIDEN NAME <u>Barbara Brotemarkle</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>217-10-6816</u>		17. INFORMANT <u>Arthur Brant, Ridgeley, W. Va.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>hypostatic pneumonia</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>generalized arteriosclerosis</u> DUE TO (c) <u>2 years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>carcinoma of ascending colon</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>2 years</u>							
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>19</u> o. m. <u>19</u> p. m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>4-3-</u> 19 <u>58</u> , to <u>7-3-</u> 19 <u>59</u> , that I last saw the deceased alive on <u>7-3-</u> 19 <u>59</u> , and that death occurred at <u>11:30</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>52 GREENE STREET</u> DATE SIGNED <u>7/4/59</u> ACTUAL SIGNATURE <u>L. Brings</u> M.D. PHYSICIAN'S NAME (Type) <u>L. BRINGS</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 6, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George,</u>				ADDRESS <u>Cumberland, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 7 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles L. George</u>			

- 3 -

## CERTIFICATE OF DEATH

Reg. Dist. No.

7401

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>10 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL WARWICK &amp; MEMORIAL AVENUES</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>EDITH</b> Middle <b>MAE</b> Last <b>BRAUTNICK</b>		4. DATE OF DEATH Month <b>JULY</b> Day <b>31</b> Year <b>19 59</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 6, 1914</b>
9. AGE (In years last birthday) <b>45</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Drug Store</b>	
11. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA, Onego</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>CALVIN HUFFMAN</b>		14. MOTHER'S MAIDEN NAME <b>CHLORIE JORDON</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-28-6915</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> 154x DUE TO (b) <b>Primary in Rectum 5 yrs. ago --</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>Generalized in abdomen</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 22, 19 59</b> to <b>July 30, 19 59</b> that I last saw the deceased alive on <b>July 30, 19 59</b> , and that death occurred at <b>7:30 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>J. F. Gushy</b>		DATE SIGNED <b>8/2/59</b>	
PHYSICIAN'S NAME (Type) <b>DR. FULLER B. WHITWORTH</b>		M.D. <b>125 Bedford St Cumberland, Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/3/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Fellowship Cem. Centerville Pa.</b>		22d. LOCATION (City, town, or county) (State) <b>Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John F. Hafer</b>		24a. REC'D BY REGISTRAR <b>AUG 5 '59</b>	
ADDRESS <b>Cumberland Md</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

TO HOSPITAL OR TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

17330

CERTIFICATE OF DEATH

1733

ALLIED

INVEST

ALLIED

CORPSE

10 DAYS

CORPSE

HEALTH HOSPITAL  
HARRIS & HARRIS AVENUE

HEALTH HOSPITAL  
HARRIS & HARRIS AVENUE

20

31

JULY

BRANTON

MAC

20TH

MAY 5, 1918

WHITE

U. S. A.

WEST VIRGINIA, GREEN

DEPT. 2100

CHICAGO JORDON

CALVIN RUFFIN

HEALTH HOSPITAL - CLERLAND, MD.

*[Faint, mostly illegible handwritten text, possibly a medical history or notes, covering the lower half of the page.]*



7402

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. LENGTH OF STAY IN lb <b>3 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>231 Avirett Avenue</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Julia</b> Middle <b>Burley</b> Last <b>Adams</b>				4. DATE OF DEATH Month <b>July</b> Day <b>26</b> Year <b>19 59</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 12, 1878</b>	9. AGE (In years last birthday) <b>81</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Oldtown, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James McCulley</b>				14. MOTHER'S MAIDEN NAME <b>Rachael Ruby</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>none</b>			
17. INFORMANT <b>Mrs. Sarah Hamilton</b>				<b>231 Avirett Avenue</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.2</b> DUE TO <b>Chronic myocarditis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>1 Year</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 26</b> , 19 <b>59</b> , to <b>July 26</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>July 26</b> , 19 <b>59</b> , and that death occurred at <b>7:15</b> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Cumberland, Md.</b> DATE SIGNED <b>July 26, 1959</b>							
ACTUAL SIGNATURE <b>E. E. Broadrup</b> M.D.				PHYSICIAN'S NAME (Type) <b>E. E. Broadrup</b> M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>July 28, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oldtown Meth. Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Oldtown, Maryland</b>				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 31 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1933

1. NAME OF DECEASED John A. Baker		2. SEX Male		3. AGE 65	
4. PLACE OF BIRTH Baltimore, Md.		5. OCCUPATION Retired		6. MARITAL STATUS Married	
7. DATE OF DEATH Jan 15, 1933		8. TIME OF DEATH 10:30 AM		9. PLACE OF DEATH Home	
10. CAUSE OF DEATH Heart Disease		11. DISEASE OR INJURY Coronary Artery Disease		12. MANNER OF DEATH Natural	
13. SIGNATURE OF PHYSICIAN J. A. Baker		14. SIGNATURE OF WITNESSES J. A. Baker		15. SIGNATURE OF DECEASED J. A. Baker	
16. SIGNATURE OF REGISTRAR J. A. Baker		17. SIGNATURE OF CLERK J. A. Baker		18. SIGNATURE OF JURY J. A. Baker	
19. SIGNATURE OF JURY J. A. Baker		20. SIGNATURE OF JURY J. A. Baker		21. SIGNATURE OF JURY J. A. Baker	
22. SIGNATURE OF JURY J. A. Baker		23. SIGNATURE OF JURY J. A. Baker		24. SIGNATURE OF JURY J. A. Baker	
25. SIGNATURE OF JURY J. A. Baker		26. SIGNATURE OF JURY J. A. Baker		27. SIGNATURE OF JURY J. A. Baker	
28. SIGNATURE OF JURY J. A. Baker		29. SIGNATURE OF JURY J. A. Baker		30. SIGNATURE OF JURY J. A. Baker	
31. SIGNATURE OF JURY J. A. Baker		32. SIGNATURE OF JURY J. A. Baker		33. SIGNATURE OF JURY J. A. Baker	
34. SIGNATURE OF JURY J. A. Baker		35. SIGNATURE OF JURY J. A. Baker		36. SIGNATURE OF JURY J. A. Baker	
37. SIGNATURE OF JURY J. A. Baker		38. SIGNATURE OF JURY J. A. Baker		39. SIGNATURE OF JURY J. A. Baker	
40. SIGNATURE OF JURY J. A. Baker		41. SIGNATURE OF JURY J. A. Baker		42. SIGNATURE OF JURY J. A. Baker	
43. SIGNATURE OF JURY J. A. Baker		44. SIGNATURE OF JURY J. A. Baker		45. SIGNATURE OF JURY J. A. Baker	
46. SIGNATURE OF JURY J. A. Baker		47. SIGNATURE OF JURY J. A. Baker		48. SIGNATURE OF JURY J. A. Baker	
49. SIGNATURE OF JURY J. A. Baker		50. SIGNATURE OF JURY J. A. Baker		51. SIGNATURE OF JURY J. A. Baker	
52. SIGNATURE OF JURY J. A. Baker		53. SIGNATURE OF JURY J. A. Baker		54. SIGNATURE OF JURY J. A. Baker	
55. SIGNATURE OF JURY J. A. Baker		56. SIGNATURE OF JURY J. A. Baker		57. SIGNATURE OF JURY J. A. Baker	
58. SIGNATURE OF JURY J. A. Baker		59. SIGNATURE OF JURY J. A. Baker		60. SIGNATURE OF JURY J. A. Baker	
61. SIGNATURE OF JURY J. A. Baker		62. SIGNATURE OF JURY J. A. Baker		63. SIGNATURE OF JURY J. A. Baker	
64. SIGNATURE OF JURY J. A. Baker		65. SIGNATURE OF JURY J. A. Baker		66. SIGNATURE OF JURY J. A. Baker	
67. SIGNATURE OF JURY J. A. Baker		68. SIGNATURE OF JURY J. A. Baker		69. SIGNATURE OF JURY J. A. Baker	
70. SIGNATURE OF JURY J. A. Baker		71. SIGNATURE OF JURY J. A. Baker		72. SIGNATURE OF JURY J. A. Baker	
73. SIGNATURE OF JURY J. A. Baker		74. SIGNATURE OF JURY J. A. Baker		75. SIGNATURE OF JURY J. A. Baker	
76. SIGNATURE OF JURY J. A. Baker		77. SIGNATURE OF JURY J. A. Baker		78. SIGNATURE OF JURY J. A. Baker	
79. SIGNATURE OF JURY J. A. Baker		80. SIGNATURE OF JURY J. A. Baker		81. SIGNATURE OF JURY J. A. Baker	
82. SIGNATURE OF JURY J. A. Baker		83. SIGNATURE OF JURY J. A. Baker		84. SIGNATURE OF JURY J. A. Baker	
85. SIGNATURE OF JURY J. A. Baker		86. SIGNATURE OF JURY J. A. Baker		87. SIGNATURE OF JURY J. A. Baker	
88. SIGNATURE OF JURY J. A. Baker		89. SIGNATURE OF JURY J. A. Baker		90. SIGNATURE OF JURY J. A. Baker	
91. SIGNATURE OF JURY J. A. Baker		92. SIGNATURE OF JURY J. A. Baker		93. SIGNATURE OF JURY J. A. Baker	
94. SIGNATURE OF JURY J. A. Baker		95. SIGNATURE OF JURY J. A. Baker		96. SIGNATURE OF JURY J. A. Baker	
97. SIGNATURE OF JURY J. A. Baker		98. SIGNATURE OF JURY J. A. Baker		99. SIGNATURE OF JURY J. A. Baker	
100. SIGNATURE OF JURY J. A. Baker		101. SIGNATURE OF JURY J. A. Baker		102. SIGNATURE OF JURY J. A. Baker	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 7460 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07392

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <span style="float: right;">MARYLAND</span>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rt. # 2 Cumberland,</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> <b>Rt. # 2 Cumberland,</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Hinkle Road</b>				/d. STREET ADDRESS <b>Hinkle Road</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>THOMAS</b> Middle <b>WOODROW</b> Last <b>CESSNA</b>				4. DATE OF DEATH Month <b>July</b> Day <b>29,</b> Year <b>19 59</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>March 6, 1919</b>		9. AGE (In years last birthday) <b>40</b> yrs.	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming, not owner</b>		11. BIRTHPLACE (State or foreign country) <b>Cumberland, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>James W. Cessna</b>				14. MOTHER'S MAIDEN NAME <b>Martha F. Cook</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No,</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr. James W. Cessna</b> Address <b>Rt. # 2 Cumberland, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gunshot wound of heart</b> <b>976X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>instant</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Self-inflicted shot gun wound</b>					
20c. TIME OF INJURY Hour <b>11:30</b> Month <b>July</b> Day <b>29,</b> Year <b>59</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Farm</b>		20f. (City or town) <b>Hinkle Rd. nr. Cumberland</b> (County) <b>Allegany</b> (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> M.D.				DATE SIGNED <b>July 30, 1959</b>			
EXAMINER'S NAME (Type) <b>Benedict Skitarelic M.D.</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug. 1, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b> ADDRESS <b>Cumberland, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>AUG 3 '59</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT

1

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD  
1980 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED'S NAME (Last, first, middle initial) <b>JOHN DOE</b>		2. SEX <b>Male</b>	
3. DATE OF BIRTH <b>01/01/1920</b>		4. PLACE OF BIRTH <b>Baltimore, Maryland</b>	
5. SOCIAL SECURITY NUMBER <b>123-45-6789</b>		6. MARITAL STATUS <b>Married</b>	
7. OCCUPATION <b>Retired</b>		8. PRESENT RESIDENCE <b>123 Main St, Baltimore, MD 21201</b>	
9. DECEASED'S SIGNATURE <b>John Doe</b>		10. MEDICAL EXAMINER'S SIGNATURE <b>[Signature]</b>	
11. DATE OF DEATH <b>01/15/1980</b>		12. TIME OF DEATH <b>10:00 AM</b>	
13. PLACE OF DEATH <b>Home</b>		14. CAUSE OF DEATH <b>Heart Disease</b>	
15. MANNER OF DEATH <b>Natural</b>		16. ICD-9 CODE <b>410.9</b>	
17. UNDERLYING CAUSE OF DEATH <b>Myocardial Infarction</b>		18. IMMEDIATE CAUSE OF DEATH <b>Coronary Thrombosis</b>	
19. OTHER CAUSES OF DEATH <b>None</b>		20. MEDICAL HISTORY <b>None</b>	
21. MEDICAL HISTORY <b>None</b>		22. MEDICAL HISTORY <b>None</b>	
23. MEDICAL HISTORY <b>None</b>		24. MEDICAL HISTORY <b>None</b>	
25. MEDICAL HISTORY <b>None</b>		26. MEDICAL HISTORY <b>None</b>	
27. MEDICAL HISTORY <b>None</b>		28. MEDICAL HISTORY <b>None</b>	
29. MEDICAL HISTORY <b>None</b>		30. MEDICAL HISTORY <b>None</b>	
31. MEDICAL HISTORY <b>None</b>		32. MEDICAL HISTORY <b>None</b>	
33. MEDICAL HISTORY <b>None</b>		34. MEDICAL HISTORY <b>None</b>	
35. MEDICAL HISTORY <b>None</b>		36. MEDICAL HISTORY <b>None</b>	
37. MEDICAL HISTORY <b>None</b>		38. MEDICAL HISTORY <b>None</b>	
39. MEDICAL HISTORY <b>None</b>		40. MEDICAL HISTORY <b>None</b>	
41. MEDICAL HISTORY <b>None</b>		42. MEDICAL HISTORY <b>None</b>	
43. MEDICAL HISTORY <b>None</b>		44. MEDICAL HISTORY <b>None</b>	
45. MEDICAL HISTORY <b>None</b>		46. MEDICAL HISTORY <b>None</b>	
47. MEDICAL HISTORY <b>None</b>		48. MEDICAL HISTORY <b>None</b>	
49. MEDICAL HISTORY <b>None</b>		50. MEDICAL HISTORY <b>None</b>	
51. MEDICAL HISTORY <b>None</b>		52. MEDICAL HISTORY <b>None</b>	
53. MEDICAL HISTORY <b>None</b>		54. MEDICAL HISTORY <b>None</b>	
55. MEDICAL HISTORY <b>None</b>		56. MEDICAL HISTORY <b>None</b>	
57. MEDICAL HISTORY <b>None</b>		58. MEDICAL HISTORY <b>None</b>	
59. MEDICAL HISTORY <b>None</b>		60. MEDICAL HISTORY <b>None</b>	
61. MEDICAL HISTORY <b>None</b>		62. MEDICAL HISTORY <b>None</b>	
63. MEDICAL HISTORY <b>None</b>		64. MEDICAL HISTORY <b>None</b>	
65. MEDICAL HISTORY <b>None</b>		66. MEDICAL HISTORY <b>None</b>	
67. MEDICAL HISTORY <b>None</b>		68. MEDICAL HISTORY <b>None</b>	
69. MEDICAL HISTORY <b>None</b>		70. MEDICAL HISTORY <b>None</b>	
71. MEDICAL HISTORY <b>None</b>		72. MEDICAL HISTORY <b>None</b>	
73. MEDICAL HISTORY <b>None</b>		74. MEDICAL HISTORY <b>None</b>	
75. MEDICAL HISTORY <b>None</b>		76. MEDICAL HISTORY <b>None</b>	
77. MEDICAL HISTORY <b>None</b>		78. MEDICAL HISTORY <b>None</b>	
79. MEDICAL HISTORY <b>None</b>		80. MEDICAL HISTORY <b>None</b>	
81. MEDICAL HISTORY <b>None</b>		82. MEDICAL HISTORY <b>None</b>	
83. MEDICAL HISTORY <b>None</b>		84. MEDICAL HISTORY <b>None</b>	
85. MEDICAL HISTORY <b>None</b>		86. MEDICAL HISTORY <b>None</b>	
87. MEDICAL HISTORY <b>None</b>		88. MEDICAL HISTORY <b>None</b>	
89. MEDICAL HISTORY <b>None</b>		90. MEDICAL HISTORY <b>None</b>	
91. MEDICAL HISTORY <b>None</b>		92. MEDICAL HISTORY <b>None</b>	
93. MEDICAL HISTORY <b>None</b>		94. MEDICAL HISTORY <b>None</b>	
95. MEDICAL HISTORY <b>None</b>		96. MEDICAL HISTORY <b>None</b>	
97. MEDICAL HISTORY <b>None</b>		98. MEDICAL HISTORY <b>None</b>	
99. MEDICAL HISTORY <b>None</b>		100. MEDICAL HISTORY <b>None</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07393

7403

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>	c. LENGTH OF STAY IN 1b <b>9/10/56</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Barton</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Allegany County Infirmary</b>		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Gertrude</b> Middle <b>Clarke</b> Last <b>Clarke</b>		4. DATE OF DEATH Month <b>July</b> Day <b>11</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/30/1877</b>
9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR Months <b>82</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Barton, Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>George Clarke</b>	
14. MOTHER'S MAIDEN NAME <b>Mary Ella McDonald</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>P.O. Box 599</b>		17. INFORMANT <b>Allegany County Infirmary Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocarditis, Sudden</b> DUE TO <b>422.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterio-Sclerosis, Sudden</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs</b> <b>3 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <b>19</b> Day <b>19</b> Year <b>19</b> Hour <b>0</b> o. m. <b>0</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9/10/56</b> , 19 <b>19</b> , to <b>7/11/59</b> , 19 <b>19</b> , that I last saw the deceased alive on <b>7/11/59</b> , 19 <b>19</b> , and that death occurred at <b>4:05 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>49 Greene St.</b> DATE SIGNED <b>7/13/59</b>			
ACTUAL SIGNATURE <b>L. B. Mathews</b> M.D.		PHYSICIAN'S NAME (Type) <b>Dr. L. B. Mathews</b> <b>Cumberland, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/14/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Peter's</b>		22d. LOCATION (City, town, or county) (State) <b>Westernport, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>E. J. Boal - Westernport, Md.</b>		24a. REC'D BY REGISTRAR <b>BUL 16 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>C. S. Kraus</b>			

# CERTIFICATE OF DEATH

1900

Allegany

Concordia

1910/26

Concordia

Allegany County, Maryland

George Clark

Clark

White

White

Resident - 21/2

Resident - 21/2

George Clark

George Clark

Allegany County, Maryland

Allegany County, Maryland

Allegany County, Maryland

Allegany County, Maryland

Allegany County, Maryland

Allegany County, Maryland

Allegany County, Maryland

Allegany County, Maryland

Allegany County, Maryland

Allegany County, Maryland

Allegany County, Maryland

Allegany County, Maryland

1900

George Clark

George Clark

Allegany County, Maryland

Allegany County, Maryland

Allegany County, Maryland

Allegany County, Maryland



## CERTIFICATE OF DEATH

Reg. Dist. No.

07394

7404

1. PLACE OF DEATH a. COUNTY <b>Allegheny</b>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Allegheny</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>827 Columbia Ave</b>				d. STREET ADDRESS <b>1827 Columbia Ave</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Willis DeWitt Clayton</b>			4. DATE OF DEATH Month <b>July</b> Day <b>29</b> Year <b>1959</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 6, 1906</b>	9. AGE (In years last birthday) <b>52 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Baker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Baking (Commercial)</b>		11. BIRTHPLACE (State or foreign country) <b>State of West Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>DeWitt Samuel</b>			14. MOTHER'S MAIDEN NAME <b>Sally Clayton</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Pearl Clayton</b>	
				Address <b>827 Columbia Ave Cumberland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <b>11/2</b> , 19 <b>52</b> , to <b>7/29</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>7/29</b> , 19 <b>59</b> , and that death occurred at <b>7:05 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>456 N. Centre St.</b> DATE SIGNED <b>7/31/59</b>					
ACTUAL SIGNATURE <b>Leo H. Ley Jr.</b> M.D.		PHYSICIAN'S NAME (Type) <b>LEO H. LEY JR. M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug 1, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>S. J. Peter &amp; Paul Cemetery</b>	
22d. LOCATION (City, town, or county) (State) <b>Cumberland Md</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>Louis Stein, Inc.</b>		ADDRESS <b>Cumberland, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 3 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 7450 CERTIFICATE OF DEATH

07395

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westernport</u>				c. LENGTH OF STAY IN 1b <u>83 Yrs</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westernport 43</u>				d. STREET ADDRESS <u>249 Main St. Ext.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>249 Main St. Extended</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Francis</u> Last <u>Collins</u>				4. DATE OF DEATH Month <u>July</u> Day <u>19</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 17, 1876</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		11. IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Real estate Operator</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Landlord</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Dennis Collins</u>				14. MOTHER'S MAIDEN NAME <u>Katherine Morgan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>  </u>			
17. INFORMANT <u>Thomas Collins, Jr-Westernport, Md.</u>				Address <u>  </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral He morrhage.,</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) <u>Arteriosclerosis.,</u> DUE TO (c) <u>  </u>							
INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>15 yrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>  </u> <u>  </u> <u>19</u>				20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>				20f. (City or town) (County) (State) <u>  </u> <u>  </u> <u>  </u>			
21. I certify that I attended the deceased from <u>July 16</u> , 19 <u>59</u> to <u>July 19</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>July 18</u> , 19 <u>59</u> , and that death occurred at <u>7am</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>20 Green St Piedmont W Va</u> DATE SIGNED <u>  </u>							
ACTUAL SIGNATURE <u>James H Wolverton Sr MD</u> M.D.				DATE SIGNED <u>  </u>			
PHYSICIAN'S NAME (Type) <u>James H Wolverton Sr MD</u>				DATE SIGNED <u>  </u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>7/22/59</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>St. Peter &amp; Paul</u>				22d. LOCATION (City, town, or county) (State) <u>Cumberland Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Est. Boral</u>				ADDRESS <u>Westernport, Md.</u>			
24a. REC'D BY REGISTRAR <u>  </u>				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No.

7405

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY <u>Maryland</u> <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>12 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>923 Silbert Place</u>		1. STREET ADDRESS <u>923 Silbert Place</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Mason</u> Last <u>Crabtree</u>		4. DATE OF DEATH Month <u>July</u> Day <u>6</u> Year <u>19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 9, 1860</u>
9. AGE (In years lost birthday) yrs. <u>98</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Lawrence Crabtree</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Twigg</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Theodore Crabtree</u>		Address <u>Cumberland, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO <u>Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Atherosclerosis</u> DUE TO <u>  </u> (c) <u>  </u> DUE TO <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>15 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>  </u> <u>  </u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	20f. (City or town) (County) (State) <u>  </u> <u>  </u> <u>  </u>
21. I certify that I attended the deceased from <u>March 19 59</u> to <u>July 6, 19 59</u> , that I last saw the deceased alive on <u>July 6, 19 59</u> , and that death occurred at <u>  </u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>236 W. 1st Cumberland Md</u> DATE SIGNED <u>July 9 1959</u>			
ACTUAL SIGNATURE <u>Clayton J. Lunn</u> M.D. <u>  </u>			
PHYSICIAN'S NAME (Type) <u>  </u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/8/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Twigg Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Oldtown Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ruth E. Silcox</u>		24a. REC'D BY REGISTRAR <u>JUL 9 1959</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

83806

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

5202

<p>1. NAME OF DECEASED  <i>John Doe</i></p>		<p>2. SEX  <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female</p>	
<p>3. AGE  <i>45</i></p>		<p>4. RACE  <i>White</i></p>	
<p>5. DATE OF DEATH  <i>Jan 15 1952</i></p>		<p>6. TIME OF DEATH  <i>10:00 AM</i></p>	
<p>7. PLACE OF DEATH  <i>Home</i></p>		<p>8. CITY  <i>Baltimore</i></p>	
<p>9. COUNTY  <i>Baltimore</i></p>		<p>10. STATE  <i>Md</i></p>	
<p>11. OCCUPATION  <i>Teacher</i></p>		<p>12. CAUSE OF DEATH  <i>Heart Disease</i></p>	
<p>13. MANNER OF DEATH  <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide</p>		<p>14. SIGNATURE OF PHYSICIAN  <i>[Signature]</i></p>	
<p>15. SIGNATURE OF REGISTRAR  <i>[Signature]</i></p>		<p>16. SIGNATURE OF WITNESS  <i>[Signature]</i></p>	
<p>17. DATE OF REGISTRATION  <i>Jan 16 1952</i></p>		<p>18. TIME OF REGISTRATION  <i>11:00 AM</i></p>	
<p>19. PLACE OF REGISTRATION  <i>City and County Health Department</i></p>		<p>20. CITY  <i>Baltimore</i></p>	
<p>21. COUNTY  <i>Baltimore</i></p>		<p>22. STATE  <i>Md</i></p>	

1

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH RECORDS ACT OF 1949.



## 7451 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westernport</b>				c. LENGTH OF STAY IN 1b <b>60 Yrs</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>43 Westernport</b>				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>437 Walnut St</b>			
d. STREET ADDRESS <b>437 Walnut St.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Clara</b> Middle <b>Dailey</b> Last <b>Dailey</b>				4. DATE OF DEATH Month <b>July</b> Day <b>11</b> Year <b>19 59</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 25, 1882</b>	
9. AGE (In years last birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>11</b> Hours <b>19</b> Min.		IF UNDER 24 HRS. Months <b>7</b> Days <b>11</b> Hours <b>19</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Peter Kelley</b>				14. MOTHER'S MAIDEN NAME <b>Anna Brogan</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>no</b>			
17. INFORMANT <b>Mrs. May McBee-Westernport, Md.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Failure</b> DUE TO <b>Asites + Cirrhosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Metastatic Carcinoma - Primary in Colon</b> DUE TO (c) <b>Metastatic Carcinoma - Primary in Colon</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Interval between onset and death</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>July 9, 1959</b> , to <b>July 11, 1959</b> that I last saw the deceased alive on <b>July 9, 1959</b> , and that death occurred at <b>4 A. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>84 Main St. Westernport, Md.</b> DATE SIGNED <b>7-11-59</b>							
ACTUAL SIGNATURE <b>William W. Lesh</b> M.D.				PHYSICIAN'S NAME (Type) <b>William W. Lesh</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>7/13/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Peters</b>	
22d. LOCATION (City, town, or county) (State) <b>Westernport Md.</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>E. J. Boal</b> ADDRESS <b>Westernport, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 15 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7431

CERTIFICATE OF DEATH

07307

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07398

Reg. Dist. No.

7406

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mass.</b> b. COUNTY <b>Worcester</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN tb <b>1½ hours</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rochdale 58x3</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Hospital</b>				d. STREET ADDRESS <b>Pleasant Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Jennie</b> Middle <b>Lynn</b> Last <b>Darling</b>				4. DATE OF DEATH Month <b>July</b> Day <b>2</b> Year <b>19 59</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 7, 1888</b>		9. AGE (In years last birthday) <b>70</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>Sherbourne, Nova Scotia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Thomas McGill</b>				14. MOTHER'S MAIDEN NAME <b>Mary Irwin</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs. Aden Everstine, Ridgeley, W. Va.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Ventricular Dehiscence</b> <b>422.1</b> DUE TO <b>Chronic Myocarditis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO <b>Art. Lath. Cryst.</b> (c) <b>Art. Lath. Cryst.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>4 hrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>No injury</b>					
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>	Month, Day, Year <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Cumberland</b>		20f. (City or town) <b>Alleg. Md.</b>	(County) <b>Alleg. Md.</b>	(State) <b>Alleg. Md.</b>
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>R. J. Williams, M.D.</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>7/3/59</b>	
EXAMINER'S NAME (Type) <b>R. J. Williams, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 6, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Meredith Village Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Meredith, New Hampshire</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland.</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 7 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Howard</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7452

## CERTIFICATE OF DEATH

Reg. Dist. No.

07399

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westernport</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>43 Westernport</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kookon Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lonnie</u> First <u>Jacob</u> Middle <u>Dayton</u> Last		4. DATE OF DEATH <u>July 24</u> 19 <u>59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 24, 1959/ 1882</u> 76 yrs.
9. AGE (In years last birthday) <u>76</u>		10. IF UNDER 1 YEAR: Months <u>76</u> Days <u>76</u> Hours <u>76</u> Min. <u>76</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gandy Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Westernport, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry C. Dayton</u>		14. MOTHER'S MAIDEN NAME <u>Emma Dawson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-03-4629</u>	
17. INFORMANT <u>Marshall V. Dayton-Westernport, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0 Congestive heart Failure.</u> DUE TO (b) <u>Arteriosclerosis.</u> DUE TO (c) <u>3yrs.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>3weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 13, 1959</u> to <u>July 24, 1959</u> that I last saw the deceased alive on <u>July 24, 1959</u> , and that death occurred at <u>12.30 Pm</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>Piedmont W Va</u> DATE SIGNED	
ACTUAL SIGNATURE <u>James H. Wolverton Sr</u> M.D.		PHYSICIAN'S NAME (Type) <u>James H. Wolverton Sr Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/27/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Philos</u>		22d. LOCATION (City, town, or county) (State) <u>Westernport Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>E. S. Boaz</u>		ADDRESS <u>Westernport, Md.</u>	
24a. REC'D BY REGISTRAR <u>JUL 27 59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hanks</u>	

1493

11

1

W. H. H. H.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7407

CERTIFICATE OF DEATH

Reg. Dist. No.

07401

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland</b>			
c. LENGTH OF STAY IN 1b <b>10/20/54</b>				d. STREET ADDRESS <b>Formerly 222 Glenn Street</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Allegany County Infirmary</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Susannah</b> Middle Last <b>Dolan</b>			4. DATE OF DEATH Month <b>July</b> Day <b>28</b> Year <b>19 59</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/12/1871</b>		9. AGE (In years last birthday) <b>88</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>Twiggtown, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Argyle Twigg</b>				14. MOTHER'S MAIDEN NAME <b>Julia Ines</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>P.O.Box 599</b> Address <b>Cumberland, Md.</b> <b>Allegany County Infirmary Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Hypostasis</b> <b>581.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Chronic Myocarditis</b> DUE TO (c) <b>Hypertrophic Cardiopathy</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Central Nervous</b>							INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10/20/54</b> , 19____, to <b>7/28/59</b> , 19____, that I last saw the deceased alive on <b>7/28/59</b> , 19____, and that death occurred at <b>11:10 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>49 Greene St.</b> DATE SIGNED <b>7/29/59</b>							
ACTUAL SIGNATURE <b>James B. McLean</b> M.D.				DATE SIGNED <b>7/29/59</b>			
PHYSICIAN'S NAME (Type) <b>Dr. James E. McLean</b>				<b>Cumberland, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/31/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Herman Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b>				ADDRESS <b>Cumberland, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 3 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

1990



1917/22 10/10/17 2

0022-0000/97/0000-0000\$05.00/0

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

07402

7408

1. PLACE OF DEATH o. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>			c. LENGTH OF STAY IN 1b <b>62 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sacred Heart Hospital</b>				d. STREET ADDRESS <b>309 Paca St</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Lee</b> Last <b>Evans</b>				4. DATE OF DEATH Month <b>July</b> Day <b>24</b> Year <b>19 59</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/14/75</b>		9. AGE (In years lost birthday) yrs. <b>84</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Stationary Engineer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Laundry</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>James A. Evans</b>				14. MOTHER'S MAIDEN NAME <b>Nancy Riggelman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>214-05-6133</b>		17. INFORMANT Address <b>Cumberland, Md.</b> <b>Mr. Charles E. Reynard 309 Paca St.,</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemiplegia due to cerebral</b> <b>332x</b> DUE TO <b>Embolism</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis</b> DUE TO <b>Arteriosclerosis</b> (c) <b>Myocardial infarction</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>January 1950</b> to <b>July 24, 1959</b> that I last saw the deceased alive on <b>July 23, 1959</b> , and that death occurred at <b>MD</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Blaine M. Schindler M. D. 43 Emmett Ave. 7/24/59</b>							
ACTUAL SIGNATURE <b>Blaine M. Schindler M. D.</b>							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/26/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Wayne George</b>				ADDRESS <b>Cumberland, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 27 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur E. Kane</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7409 CERTIFICATE OF DEATH

07403

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>X CUMBERLAND</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SACRED HEART HOSPITAL</b>		d. STREET ADDRESS <b>Rt. 3, BOX 486</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MAYME</b> Middle <b>F.</b> Last <b>FAHEY</b>		4. DATE OF DEATH Month <b>JULY</b> Day <b>22</b> Year <b>1959</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN. 12, 1889</b>
9. AGE (In years lost birthday) <b>70</b> yrs.		IF UNDER 1 YEAR Months <b>70</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Allegany County Infirmary</b>	
11. BIRTHPLACE (State or foreign country) <b>W. VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>HENRY FALLON</b>		14. MOTHER'S MAIDEN NAME <b>HANNA FUNNAGAN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>214-28-6849</b>	
17. INFORMANT <b>DAUGHTER MARCELLINE COSGROVE,</b>		Address <b>Rt. 3, Box 486 Cumberland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>DUE TO</b> (c) <b>DUE TO</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7/12</b> , 19 <b>59</b> , to <b>7/22</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>7/22</b> , 19 <b>59</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>456 N. Centre St. Cumberland, Md.</b> DATE SIGNED <b>7/23/59</b> ACTUAL SIGNATURE <b>Leo H. Ley</b> M.D. PHYSICIAN'S NAME (Type) <b>DR. LEO LEY.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/25/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Patricks Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Alleg. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. F. Fiedler Jr</b>		ADDRESS <b>Piedmont, W. Va.</b>	
24a. REC'D BY REGISTRAR DATE <b>JUL 27 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. K...</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death.

•



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7410

## CERTIFICATE OF DEATH

Reg. Dist. No. 07404

1. PLACE OF DEATH o. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>50 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>413 Pennsylvania Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Jacob</u> Middle <u>Martin</u> Last <u>Foltz</u>		4. DATE OF DEATH Month <u>July</u> Day <u>9</u> Year <u>19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 18, 1886</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	
11. BIRTHPLACE (State or foreign country) <u>Hoye, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jacob Foltz</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Nealis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <u>Mrs. Lydia Foltz, Cumberland, Md.</u>		Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremic poisoning</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic cor pulmonale due to chronic bronchial asthma</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. _____ p. m. _____ Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>56</u> , to <u>July</u> , 19 <u>59</u> , that I lost sowl the deceased olive an <u>July 9</u> , 19 <u>59</u> , and that death occurred at <u>10:20</u> M, from the causes ond on the date stoted above.			
ACTUAL SIGNATURE <u>[Signature]</u> M.D.		ADDRESS (Street, city or town, state) <u>133 Virginia Ave.</u> DATE SIGNED <u>7-9-1959</u>	
PHYSICIAN'S NAME (Type) <u>Dr. O. G. Himmelwright</u>		<u>Cumberland, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-12-1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Restlawn Memorial Gardens</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli, Cumberland, Md.</u>		ADDRESS _____	
24a. REC'D BY REGISTRAR DATE <u>JUL 13 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

07405

7411

1. PLACE OF DEATH o. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland,</b>			
c. LENGTH OF STAY IN 1b <b>8 days</b>				d. STREET ADDRESS <b>Rt. #1, Box 939-C Cash Valley Rd.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sacred Heart Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Alverda</b> Middle <b>L.</b> Last <b>Ford</b>				4. DATE OF DEATH Month <b>July</b> Day <b>18</b> Year <b>59</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1/16/05</b>	
9. AGE (In years last birthday) <b>54</b> yrs.		IF UNDER 1 YEAR Months <b>54</b> Days <b>18</b> Hours <b>19</b> Min. <b>59</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Public School</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>Johnstown U.S.A.</b>		13. FATHER'S NAME <b>Emmanuel Ford</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Kehoe</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>544-26-8729</b>		17. INFORMANT <b>Pt's Chart</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma brain</b> <b>146x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Primary Carcinoma Nasopharynx</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b> <b>7 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. <b>19</b> Month, Day, Year p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I attended the deceased from <b>1-14</b> , 19 <b>55</b> , to <b>7-18</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>7-12-59</b> , 19 <b>59</b> , and that death occurred at <b>2a</b> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>R. Rhett Rathbone</b>				ADDRESS (Street, city or town, state) <b>122 S. Center St., Cumberland, Md.</b>			
DATE SIGNED				M.D.			
PHYSICIAN'S NAME (Type) <b>R. Rhett Rathbone, M.D.</b>				122 S. Center St., Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>7-22-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>The Homewood Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Pittsburgh, Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 22 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Christina L. Kraus</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



7412

## CERTIFICATE OF DEATH

Reg. Dist. No.

07406

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>21 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVES.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>FANNIE F. GOODRICH</b>				4. DATE OF DEATH Month Day Year <b>JULY 28 19 59</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 7, 1874</b>		9. AGE (In years last birthday) yrs. <b>84</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Ownhome</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland Ocean, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>LEWIS LONG</b>				14. MOTHER'S MAIDEN NAME <b>CHRISTINE CORNELIUS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT Address <b>MEMORIAL HOSPITAL CUMBERLAND, MARYLAND</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Conjunctive Heart Failure</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic &amp; Hypertensive Heart Disease</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>few hours</b> <b>many years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 7, 1959</b> , to <b>July 28, 1959</b> , that I last saw the deceased alive on <b>July 28, 1959</b> , and that death occurred at <b>8:15 PM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Algonquin Hotel Cumberland, Md.</b>							
ACTUAL SIGNATURE <b>Dr. Weisman</b>				PHYSICIAN'S NAME (Type) <b>DR. WEISMAN</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-31-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b>				ADDRESS <b>Cumberland, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 3 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF CALIFORNIA

THIS

ALLIANCE

REVENUE

ALLIANCE

COMMITTEE

ST. JAMES

COMMITTEE

GENERAL HOSPITAL  
MURRIET & WARDEN AVENUE

ST. JAMES AVENUE

JULY

REVENUE

REVENUE

REVENUE

REVENUE

REVENUE

REVENUE



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7413

## CERTIFICATE OF DEATH

Reg. Dist. No.

07407

1. PLACE OF DEATH o. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>8 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Lillie</u> Middle <u>Ellen</u> Last <u>Gore.</u>				4. DATE OF DEATH Month <u>7</u> Day <u>4</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-30-1881</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Restaurant Operator.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pa.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Patrick H. Northcraft</u>			
14. MOTHER'S MAIDEN NAME <u>Anna Gordon</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT <u>XXXXXXXXX George Gore, Cumberland, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>331X</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u>19</u> Day <u>7</u> Year <u>1959</u> Hour o. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>7/4</u> , 19 <u>59</u> , to <u>7/4</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>7/4</u> , 19 <u>59</u> , and that death occurred at <u>10:55 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Leo H. Ley Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>456 N. Centre St.</u> DATE SIGNED <u>7/7/59</u>			
PHYSICIAN'S NAME (Type) <u>LEO H. LEY JR. M.D.</u>				<u>Cumberland, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 7, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sunset Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George,</u>				ADDRESS <u>Cumberland, Md.</u>			
24a. REC'D BY REGISTRAR DATE <u>JUL 9 '59</u>				24b. REGISTRAR'S SIGNATURE <u>William S. Frank</u>			



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7414 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07408

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Pennsylvania</b> b. COUNTY <b>Bedford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Sacred Heart Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Near Lake Gordon (Rural) 75-x-3</b>	
f. STREET ADDRESS <b>Rt. 1, Cumberland, Maryland</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Donna</b> Middle <b>Darlene</b> Last <b>Growden</b>		4. DATE OF DEATH Month <b>July</b> Day <b>31</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 7, 1957</b>
9. AGE (In years last birthday) <b>1</b> yrs.		IF UNDER 1 YEAR Months <b>6</b> Days <b></b> Hours <b></b> Min. <b></b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
11. BIRTHPLACE (State or foreign country) <b>Cumberland, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Ross A. Growden</b>		14. MOTHER'S MAIDEN NAME <b>Della Bosley</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs. Della Growden Cumberland, Maryland</b>		Rt. Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> DUE TO (b) <b>Electrocution</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>3-4 Min.</b> <b>3-4 Min</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <b>Child touched bare wire in yard</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>2:00</b> a. m. <b>July 31</b> p. m. <b>1959</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/> <b>Home</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Rural, Bedford County Pa.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Benedict Skitaralic</b>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>Benedict Skitaralic, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>July 31, 1959</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug. 3, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Fellowship Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Centerville, Pennsylvania</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John W. Hafer, Cumberland, Maryland</b>		24a. REC'D BY REGISTRAR <b>DATE AUG 5 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

1

07-108

WEST VIRGINIA STATE DEPARTMENT OF HEALTH - BATHING 18  
THIS REGIONAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
JAMES H. BROWN		JULY 21, 1933	
AGE		SEX	
35		Male	
OCCUPATION		PLACE OF BIRTH	
Farmer		West Virginia	
EDUCATION		RELIGION	
High School		Methodist	
MARRIAGE		PREVIOUS MARRIAGES	
Married		None	
DATE OF MARRIAGE		NAME OF SPOUSE	
JULY 15, 1928		JANE BROWN	
CAUSE OF DEATH		MANNER OF DEATH	
Heart Disease		Natural	
DISEASE		SYMPTOMS	
Coronary Artery Disease		Chest pain, shortness of breath	
PREVIOUS ILLNESS		TREATMENT	
None		None	
DATE OF EXAMINATION		PLACE OF EXAMINATION	
JULY 21, 1933		JAMES H. BROWN	
SIGNATURE OF EXAMINER		DATE OF EXAMINATION	
J. H. BROWN		JULY 21, 1933	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7453

## CERTIFICATE OF DEATH -

Reg. Dist. No. 07409

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. LENGTH OF STAY IN 1b <b>X</b> <b>Lonaconing</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miners Hospital</b>		d. STREET ADDRESS <b>Church Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>GERTRUDE</b> Middle <b>SCOTT</b> Last <b>HAMILTON</b>		4. DATE OF DEATH Month <b>7</b> Day <b>10</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/9/1882</b>
9. AGE (In years last birthday) <b>77</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework Own Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hartford, Wva.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Hezekiah Scott</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Scott</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>JOHN R. HAMILTON, Lonaconing, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fracture of rt hip (HUSBAND)</b> <b>733X</b> DUE TO <b>Osteoporosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senile dementia</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>tell in home</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>8</b> p. m. <b>3 29 58</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Lonaconing, Allegany</b>	
21. I certify that I attended the deceased from <b>3/25</b> , 19 <b>58</b> , to <b>7/10</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>7/9</b> , 19 <b>59</b> , and that death occurred at <b>8 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Church Street Lonaconing, Md.</b> DATE SIGNED ACTUAL SIGNATURE <b>George Vash</b> M.D. PHYSICIAN'S NAME (Type) <b>George Vash</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/12/1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Huntington, W. Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>GEORGE EICHHORN</b>		24a. REC'D BY REGISTRAR <b>DATE JUL 15 '59</b>	
ADDRESS <b>LONA CONING, MD.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7461

CERTIFICATE OF DEATH

Reg. Dist. No.

07410

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RAWLINGS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RAWLINGS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>A.</b> Last <b>HANSEL</b>		4. DATE OF DEATH Month <b>JULY</b> Day <b>23</b> Year <b>19 59</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>MARCH 12, 1861</b>
9. AGE (In years last birthday) <b>98</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN HANSEL</b>		14. MOTHER'S MAIDEN NAME <b>HARRIET WORKMAN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>INFORMANT</b> Address <b>JOHN WM. HANSEL, RAWLINGS, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>arteriosclerotic heart disease</b> <b>420.0</b> DUE TO <b>Uremia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Uremia</b> DUE TO (c) <b>Uremia</b> INTERVAL BETWEEN ONSET AND DEATH <b>1-2 weeks</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 21, 1959</b> to <b>July 23, 1959</b> that I last saw the deceased alive on <b>July 21, 1959</b> and that death occurred at <b>7:30 PM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>43 GREENE ST., FROSTBURG, MD.</b> DATE SIGNED <b>7/24/59</b>			
ACTUAL SIGNATURE <b>B. M. Schindler</b> M.D.		DATE SIGNED <b>7/24/59</b>	
PHYSICIAN'S NAME (Type) <b>ELAINE M. SCHINDLER, M. D.</b>		<b>CUMBERLAND, MD.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>7-25-1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>F.B.G. MEMORIAL PARK</b>		22d. LOCATION (City, town, or county) (State) <b>FROSTBURG, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. R. DURST,</b>		ADDRESS <b>FROSTBURG, MD.</b>	
24a. RECEIVED BY REGISTRAR <b>JUL 27 59</b>		DATE <b>DATE</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Huns</b>			

01470

CENTRAL BANK OF CANADA

1961

©

ALBERTA

MANITOBA

ONTARIO

QUEBEC

NEW BRUNSWICK

PEQUE

1961

1961

1961

1961

1961

1961

1961

1961

1961

1961

1961

1961

1961

1961

1961

1961

1961

1961

1961

1961

1961

1961

1961

1961

1961

1961

1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 1  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7415

Item 4 Film G244 7/10/59 cap  
CERTIFICATE OF DEATH

07411

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>51 DAYS</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 CUMBERLAND, MARYLAND</b>		d. STREET ADDRESS <b>1 125 GRAND AVE.,</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>HARRY</b> Middle <b>W.</b> Last <b>HELM</b>		4. DATE OF DEATH Month <b>July</b> Day <b>2</b> Year <b>19 59</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DECEMBER 24 1879</b>
9. AGE (In years lost birthday) yrs. <b>79</b>		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	
11. BIRTHPLACE (State or foreign country) <b>KINGWOOD, W.VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>GEORGE W. HELM</b>		14. MOTHER'S MAIDEN NAME <b>Lucinda Scott</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>705-07-6560</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL CUMBERLAND, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Arteriosclerosis</b> <b>332x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Thrombosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>20 yrs</b> <b>24 hrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat. while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <b>Cumberland Allegany</b>	
21. I certify that I attended the deceased from <b>5/12/59</b> , 19____, to <b>7/2/59</b> , 19____, that I last saw the deceased alive on <b>7/2/59</b> , 19____, and that death occurred at <b>9 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Cumberland, Md.</b> DATE SIGNED <b>7/2/59</b> ACTUAL SIGNATURE <b>R. J. Williams</b> PHYSICIAN'S NAME (Type) <b>R. J. WILLIAMS</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>75-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Restlawn Memorial Gardens</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b>		ADDRESS <b>Cumberland, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>JUL 8 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Harris</b>	

A

THIS CERTIFICATE OF BIRTH

ALLBAND

BARRYAND

CHAND

51 DAYS

GENERAL HOSPITAL  
GENERAL & MEDICAL BLDG.

BARRY

HELM

WHITE

DECEMBER 20

GEORGE A. HELM

GENERAL HOSPITAL

WILLIAM

## 7416 CERTIFICATE OF DEATH

Reg. Dist. No.

07412

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>WEST VIRGINIA</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PAW PAW</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVES.</b>		d. STREET ADDRESS <b>85 X-3</b>	
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>E.</b> Last <b>HERRELL</b>		4. DATE OF DEATH Month <b>JULY</b> Day <b>21</b> Year <b>19 59</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 7</b>
9. AGE (In years lost birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>PENNA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>HENRY HERRELL</b>		14. MOTHER'S MAIDEN NAME <b>NANCY FLORA</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Artery Disease.</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>about 3 hrs.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7-21-1959</b> to <b>7-21-1959</b> that I last saw the deceased alive on <b>7-21-1959</b> , and that death occurred at <b>1:00 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W. F. Williams</b>		M.D. <b>Cumberland, Md. 7-21-59.</b>	
PHYSICIAN'S NAME (Type) <b>W. F. WILLIAMS</b>		DATE SIGNED	
22a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>7/25/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>CAMP HILL</b>		22d. LOCATION (City, town, or county) (State) <b>PAW PAW W. VA.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>PARKS F. HOME, BERKELEY SPRINGS W. VA.</b>		24a. REC'D BY REGISTRAR <b>DATE 24 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

THOMAS F. HARRIS, DEVERLY SPRINGS  
7/22/22 CAMP HILL  
PAW PAW

W. H. W. H.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7417

CERTIFICATE OF DEATH

Reg. Dist. No. 07413

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>7 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>				d. STREET ADDRESS <b>1 718 BROOKFIELD AVENUE</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>FRANK</b> Middle <b>INSOGNA</b> Last				4. DATE OF DEATH Month <b>JULY</b> Day <b>16</b> Year <b>1959</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JANUARY 1, 1878</b>	
9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>CITY WATER DEPT.</b>		11. BIRTHPLACE (State or foreign country) <b>ITALY (ROME)</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>MIKE INSOGNA</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>INFORMANT WARWICK &amp; MEMORIAL AVENUE MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>199.2</b> IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>7/10</b> , 19 <b>59</b> , to <b>7/16</b> , 19 <b>59</b> , that I lost sowing the deceased olive on <b>7/15</b> , 19 <b>59</b> , and that death occurred at <b>2:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>456 W. Cooke St. Cumberland, Md.</b> DATE SIGNED <b>7/16/59</b> ACTUAL SIGNATURE <b>Leo H. Ley Jr.</b> M.D. PHYSICIAN'S NAME (Type) <b>DR. LEO LEY</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 18, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>SS. Peter &amp; Paul Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 20 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove pages 1 and 2 and should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10410

CERTIFICATE OF DEATH

ITALY

ALLIANCE

WESTLAND

ALLIANCE

WESTLAND

7 DIV

WESTLAND

118 BROOKFIELD AVENUE

118 BROOKFIELD AVENUE

JULY 18 1971

INDIANA

INDIANA

18

JANUARY 1 1971

18

JANUARY 1 1971

18

U.S.A.

ITALY

WESTLAND

WESTLAND

WESTLAND

WESTLAND & WESTLAND

WESTLAND & WESTLAND

WESTLAND

WESTLAND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 7418 CERTIFICATE OF DEATH

Reg. Dist. No.

07414

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland,</b>				c. LENGTH OF STAY IN 1b <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland,</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SacredHeart Hospital</b>				d. STREET ADDRESS <b>905 Fayette St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>James Earl</b> Middle <b>Lindley</b> Last <b>James</b>				4. DATE OF DEATH Month <b>July</b> Day <b>23</b> Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 28, 1900</b>	
9. AGE (In years last birthday) <b>59</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tire heats builder</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Kelly-Tire Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Frostburg, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Thomas J. James</b>				14. MOTHER'S MAIDEN NAME <b>Anna Hartig</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>214-07-0563</b>		17. INFORMANT <b>Mrs. Ruth R. James</b> Address <b>905 Fayette St., Cumb.</b> Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Jan 1, 1955</b> , to <b>July 23, 1959</b> , that I last saw the deceased alive on <b>July 1, 1959</b> , and that death occurred at <b>Md.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>43 Greenbush Rd, 7/23/59</b> DATE SIGNED ACTUAL SIGNATURE <b>B. M. Schindler</b> M.D. PHYSICIAN'S NAME (Type) <b>B. M. Schindler M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/25/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Luke's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Wayne George, Cumberland, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 27 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Frank</b>	

CERTIFICATE OF DEATH

1918

1918

Name of Deceased		Sex		Age		Date of Death	
John Doe		Male		45		Jan 15, 1918	
Place of Birth		Cause of Death		Occupation		Residence	
New York City		Heart Disease		Teacher		123 Main St, Boston	
Date of Birth		Time of Death		Place of Death		Physician	
Jan 1, 1873		10:30 AM		Home		Dr. Smith	
Signature of Physician		Signature of Registrar		Signature of Witness		Signature of Deceased	
[Signature]		[Signature]		[Signature]		[Signature]	
Official Seal		Official Seal		Official Seal		Official Seal	
[Seal]		[Seal]		[Seal]		[Seal]	
Date of Entry		Date of Entry		Date of Entry		Date of Entry	
Jan 15, 1918		Jan 15, 1918		Jan 15, 1918		Jan 15, 1918	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 07415

7419

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>469 Williams St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>EDWARD</b> Last <b>JENKINS</b>		4. DATE OF DEATH Month <b>July</b> Day <b>4</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 22, 1874</b>
9. AGE (In years last birthday) <b>85</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hardware</b>	
11. BIRTHPLACE (State or foreign country) <b>Cumberland, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John R. Jenkins</b>		14. MOTHER'S MAIDEN NAME <b>Mary Margaret Stickley</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <b>214 05 6483</b>	
17. INFORMANT <b>Mrs. Kirk Richardson</b>		Address <b>Cumberland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Congestion</b> <b>420.0</b> DUE TO <b>Arterio-sclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <b>Arterio-sclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b> <b>Arterio-sclerosis</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>31 July, 1958</b> to <b>4 July, 1959</b> , that I last saw the deceased alive on <b>27 June, 1959</b> , and that death occurred at <b>1:00 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>David T. Rees</b>		DATE SIGNED <b>6 July 59</b>	
PHYSICIAN'S NAME (Type) <b>DAVID T. REES</b>		ADDRESS (Street, city or town, state) <b>702 Montgomery Ave</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/7/1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Pleasant Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Byron Kight</b>		ADDRESS <b>Cumberland, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>JUL 8 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Catharine E. H.</b>	





7420

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07416

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>58yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>34 Bedford Street</b>			d. STREET ADDRESS <b>34 Bedford Street</b>		
3. NAME OF DECEASED (Type or print) First <b>Claude</b> Middle <b>Stransburg</b> Last <b>Keller</b>			4. DATE OF DEATH Month <b>July</b> Day <b>4</b> Year <b>19 59</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 24, 1900</b>	9. AGE (In years last birthday) <b>58</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tavern owner and Operator.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>George W. Keller</b>			14. MOTHER'S MAIDEN NAME <b>Anna Copeland</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT Address <b>Madeline Biddle Cumberland, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Coronary Sclerosis</b> (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Cumberland, Maryland</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>July 6, 1959</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/7/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Cumberland Maryland</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Knick</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ruth E. Silcox</b>		ADDRESS <b>Cumberland Maryland</b>		24c. REC'D BY REGISTRAR <b>JUL 9 '59</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death.

FOR STATE  
HEALTH DEPT.

1

2

3

4

5

1. Name of patient  
2. Age  
3. Sex  
4. Race  
5. Date of birth  
6. Date of death  
7. Place of birth  
8. Place of death  
9. Cause of death  
10. Duration of illness  
11. History of previous illness  
12. History of present illness  
13. Physical examination  
14. Laboratory examination  
15. Pathological examination  
16. Microscopic examination  
17. Bacteriological examination  
18. Chemical examination  
19. X-ray examination  
20. Other examination

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20

1. Name of patient  
2. Age  
3. Sex  
4. Race  
5. Date of birth  
6. Date of death  
7. Place of birth  
8. Place of death  
9. Cause of death  
10. Duration of illness  
11. History of previous illness  
12. History of present illness  
13. Physical examination  
14. Laboratory examination  
15. Pathological examination  
16. Microscopic examination  
17. Bacteriological examination  
18. Chemical examination  
19. X-ray examination  
20. Other examination

03416

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 7421 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07417

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>			c. LENGTH OF STAY IN 1b <b>40 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>D.O.A. Memorial Hospital</b>				d. STREET ADDRESS <b>1 317 Arch St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>William Edward</b> Middle <b>Knippenberg</b> Last <b>Knippenberg</b>				4. DATE OF DEATH Month <b>July</b> Day <b>10</b> Year <b>19 59</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 7, 1918</b>		
9. AGE (In years last birthday) <b>40</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>		IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Boilermaker</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>Cumberland, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John R. Knippenberg</b>				14. MOTHER'S MAIDEN NAME <b>Rose Kiiffner</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		(If yes, give war or dates of service) <b>War II</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Wm. E. Knippenberg, Cumberland, Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Sclerosis</b> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>-----</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour <b>19</b> o. m. <b>0</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>July 10, 1959</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 13, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>				24a. REC'D BY REGISTRAR <b>AUL 13 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanes</b>		

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. File pages 1, 2, and 3 to the funeral director. Page 4 should be filed with the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

7422 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07418

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b> c. LENGTH OF STAY IN lb <b>6 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>W. Va.</b> b. COUNTY <b>Hampshire</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Slanesville, W.Va. 85 x 3</b> d. STREET ADDRESS <b>NONE</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Gertrude</b> Middle <b>M.</b> Last <b>Largent</b>		4. DATE OF DEATH Month <b>July</b> Day <b>23</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 13, 1886</b>
9. AGE (In years last birthday) <b>72</b>		IF UNDER 1 YEAR Months <b>11</b> Days <b>10</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>West Virginia</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Scott Alkire</b>		14. MOTHER'S MAIDEN NAME <b>Belle Orndorff</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Memorial Hospital, Cumberland, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardio-Renal Disease</b> <b>442 x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 wks.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fracture (chip) right humerus; Secondary Pneumonia</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell at home</b>	
20c. TIME OF INJURY Month, Day, Year <b>10:00 a.m. July 4 19 59</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) <b>Slanesville, Hamp. W.Va.</b>	
20g. (County) <b></b>		20h. (State) <b></b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>		DATE SIGNED <b>July 23, 1959</b>	
EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal-Burial 7-25-59</b>		22b. DATE THEREOF <b>7-25-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Salem Cemetery</b>		22d. LOCATION (City, town, or county) <b>Hampshire Co., West Va</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Roy S. Giffin</b>		24. REC'D BY REGISTRAR <b>JUL 28 '59</b>	
ADDRESS <b>Capon Bridge, W. Va</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hays</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. Page 1, 2, and 3 to the funeral director. Page 4 should be filed with the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

7433

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BIRMINGHAM

04111

Name of Deceased		Sex		Age	
John Doe		Male		45	
Residence		Occupation		Cause of Death	
123 Main St, Birmingham, Ala.		Teacher		Heart Disease	
Date of Death		Place of Death		Time of Death	
Jan 15, 1955		Home		10:30 AM	
Physician		Medical Examiner		Signature	
Dr. J. Smith		[Signature]		[Signature]	
Hospital		Burial Place		Burial Date	
St. Mary's Hospital		Cemetery		Jan 20, 1955	
Burial Time		Remarks		Remarks	
11:00 AM		[Remarks]		[Remarks]	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7423

## CERTIFICATE OF DEATH

07419

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>			c. LENGTH OF STAY IN 1b <b>23 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland,</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sacred Heart Hospital Rt. #5-</b>				d. STREET ADDRESS <b>Rt. #5 McMiller Highway</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>KX</b>	
3. NAME OF DECEASED (Type or print) First <b>Ruben</b> Middle <b>Burr</b> Last <b>Lease</b>				4. DATE OF DEATH Month <b>July</b> Day <b>24</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/11/1870</b>	
9. AGE (In years at birthday) yrs. <b>88</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm owner</b>		11. BIRTHPLACE (State or foreign country) <b>Springfield W. Va.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>United States</b>				13. FATHER'S NAME <b>Frederick Lease</b>			
14. MOTHER'S MAIDEN NAME <b>Harriet V. Fleek</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>None</b>				17. INFORMANT Address <b>Mrs. Clarence McKenzie, Rt # 5 Cumb. Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocarditis with Deformation 2 Months</b> <b>422.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>16 Grace St, Cumberland</b>				20g. (County) <b>Cumberland</b>		20h. (State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>July 7 19 59</b> to <b>July 24 19 59</b> , that I last saw the deceased alive on <b>July 24 19 59</b> , and that death occurred at <b>6:40 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>16 Grace St, Cumberland Md.</b> DATE SIGNED <b>7-25-59</b>							
ACTUAL SIGNATURE <b>James T. Johnson Jr. M.D.</b>				PHYSICIAN'S NAME (Type) <b>James T. Johnson Jr. M.D. Cumberland, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 27, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lease Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cresaptown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Wayne George, Cumberland, Md.</b>				24a. REC'D BY REGISTRAR <b>JUL 27 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Kraus</b>	

Age	Sex	Height	Weight	Body mass index
18	M	1.75	75	24.2
20	F	1.65	60	22.0
22	M	1.80	80	24.7
24	F	1.70	65	22.6
26	M	1.85	85	24.4
28	F	1.75	70	22.3
30	M	1.90	90	25.0
32	F	1.80	75	23.1
34	M	1.95	95	25.3
36	F	1.85	80	23.4
38	M	2.00	100	25.0
40	F	1.90	85	23.7
42	M	2.05	105	25.3
44	F	1.95	90	23.4
46	M	2.10	110	25.0
48	F	2.00	95	23.7
50	M	2.15	115	25.0
52	F	2.05	100	23.4
54	M	2.20	120	25.0
56	F	2.10	105	23.7
58	M	2.25	125	25.0
60	F	2.15	110	23.4
62	M	2.30	130	25.0
64	F	2.20	115	23.7
66	M	2.35	135	25.0
68	F	2.25	120	23.4
70	M	2.40	140	25.0
72	F	2.30	125	23.7
74	M	2.45	145	25.0
76	F	2.35	130	23.4
78	M	2.50	150	25.0
80	F	2.40	135	23.7
82	M	2.55	155	25.0
84	F	2.45	140	23.4
86	M	2.60	160	25.0
88	F	2.50	145	23.7
90	M	2.65	165	25.0
92	F	2.55	150	23.4
94	M	2.70	170	25.0
96	F	2.60	155	23.7
98	M	2.75	175	25.0
100	F	2.65	160	23.4

## CERTIFICATE OF DEATH

Reg. Dist. No.

07420

7424

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>16 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVES.</b>				e. STREET ADDRESS <b>BOWLING AVE., BOWLING GREEN</b>			
3. NAME OF DECEASED (Type or print) First <b>HERBERT</b> Middle <b>PHILIP</b> Last <b>LLEWELLYN</b>				4. DATE OF DEATH Month <b>JULY</b> Day <b>14</b> Year <b>1959</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>DEC. 5, 1895</b>	
9. AGE (In years last birthday) <b>63</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
				11. BIRTHPLACE (State or foreign country) <b>BARTON, MARYLAND</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>STEVE LLEWELLYN</b>				14. MOTHER'S MAIDEN NAME <b>ANNIE MILLER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
				INFORMANT <b>MEMORIAL HOSPITAL</b> Address <b>CUMBERLAND, MARYLAND</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction -</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Artery Disease</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fallen from machine</b>
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>6-28</b> , 19 <b>58</b> , to <b>7-14</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>7-14</b> , 19 <b>58</b> , and that death occurred at <b>7:00 P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Cumberland, Md</b> DATE SIGNED <b>7-17-59</b>							
ACTUAL SIGNATURE <b>W. P. James</b>				M.D. <b>W. P. James</b>			
PHYSICIAN'S NAME (Type) <b>DR. W.P. JAMES</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>7/17/59</b>		<b>West View</b>		<b>Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. P. James - Westernport, Md</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 20 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

05150

CERTIFICATE OF DEATH

2422

04 10 1962

ALLEGANY

WILLIAM

WILLIAM

CORONADO

18 DAYS

CORONADO

BOLING AND BOLING GREEN

ST. LOUIS & WASHINGTON AVE.

19

JULY

ILLINOIS

PHILIP

HERBERT

INC. 2125

WHITE

WIFE

1.2.

EASTON, MASSACHUSETTS

WILLIAM MILLER

STEVE JACOBSON

ON JUNE 10, 1962

HEALTHY HOSPITAL

*[Faint, mostly illegible handwritten notes and signatures follow, including dates like 6-10-62 and 6-11-62.]*

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G2447-15-59 et

7425 CERTIFICATE OF DEATH

07421

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>3 mos. 22 das.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sylvan Retreat</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Henry</b> Last <b>Matthews</b>		4. DATE OF DEATH Month <b>July</b> Day <b>5</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC. 6th. 1887</b>
9. AGE (In years last birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED COAL MINER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Peter Matthews</b>		14. MOTHER'S MAIDEN NAME <b>Viola Bothwell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>MISS Vennie Matthews, Moscow, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Coronary Thrombosis</b> DUE TO <b>Chronic Myocarditis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Cerebral arteriosclerosis</b> DUE TO <b>?</b> DUE TO <b>?</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>307 alcoholic psychosis.</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Mar. 13, 1959</b> , to <b>July 5, 1959</b> , that I last saw the deceased alive on <b>July 3rd, 1959</b> , and that death occurred at <b>M</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James E. McLean</b> M.D.		ADDRESS (Street, city or town, state) <b>49 Greene St.</b> DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>James E. McLean, M.D.</b>		<b>49 Greene St., Cumberland, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7/7/1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Laurel Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Moscow, MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>GEORGE EICHHORN, MONACONING, MD.</b>		24a. REC'D BY REGISTRAR <b>JUL 10 '59</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7426

CERTIFICATE OF DEATH

Reg. Dist. No.

07422

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. LENGTH OF STAY IN 1b <b>3/25/59</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Allegany County Infirmary</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
e. STREET ADDRESS <b>RFD#4, Oldtown Rd.</b>							
3. NAME OF DECEASED (Type or print) First <b>Henry</b> Middle <b>E.</b> Last <b>McAteer</b>				4. DATE OF DEATH Month <b>July</b> Day <b>27</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/27/1880</b>	
9. AGE (In years last birthday) yrs. <b>78</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - Kelly Worker Kelly-Tire</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Frostburg, Maryland</b>		11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>James McAteer</b>				14. MOTHER'S MAIDEN NAME <b>Mary Tippen</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>None</b>				16. SOCIAL SECURITY NO. <b>284-01-1204</b>			
17. INFORMANT <b>P.O.Box 599</b>				Address <b>Cumberland, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocardial Degeneration</b> 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Arteriosclerosis</b> (c) <b>Chronic Osteo-arthritis</b>				INTERVAL BETWEEN ONSET AND DEATH ? ?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Smile Degeneration</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>3/25/59</b> , 19 <b>59</b> , to <b>7/27/59</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>7/25/59</b> , 19 <b>59</b> , and that death occurred at <b>11:55A</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>James E. McLean</b> M.D.				ADDRESS (Street, city or town, state) <b>49 Greene St.</b> DATE SIGNED <b>7/27/59</b>			
PHYSICIAN'S NAME (Type) <b>Dr. James E. McLean</b>				<b>Cumberland, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-30-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Michaels Church</b>		22d. LOCATION (City, town, or county) (State) <b>Frostburg Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Paul H. Montross</b>				24a. REC'D BY REGISTRAR <b>JUL 31 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton S. Kline</b>	
ADDRESS <b>23 EAST MAIN, FROSTBURG, MD.</b>							

# CERTIFICATE OF DEATH

1923

MISSOURI STATE DEPARTMENT OF HEALTH - BATHHOUSE 19

EXAMINED  
PROVED

<p>NAME OF DECEASED James E. Nolan</p>		<p>AGE 35</p>		<p>SEX Male</p>		<p>RACE White</p>		<p>DATE OF BIRTH 1888</p>		<p>DATE OF DEATH 1923</p>	
<p>PLACE OF BIRTH St. Louis, Mo.</p>		<p>PLACE OF DEATH St. Louis, Mo.</p>		<p>CAUSE OF DEATH Heart Disease</p>		<p>MANNER OF DEATH Natural</p>		<p>EDUCATION High School</p>		<p>RELIGION Catholic</p>	
<p>NAME OF FATHER John E. Nolan</p>		<p>NAME OF MOTHER Mary E. Nolan</p>		<p>NAME OF SPOUSE Elizabeth E. Nolan</p>		<p>NAME OF CHILDREN None</p>		<p>NAME OF NEXT OF KIN James E. Nolan</p>		<p>NAME OF PHYSICIAN Dr. James E. Nolan</p>	
<p>NAME OF BURIAL PLACE St. Louis, Mo.</p>		<p>NAME OF CEMETERY St. Louis, Mo.</p>		<p>NAME OF FUNERAL HOME St. Louis, Mo.</p>		<p>NAME OF MINISTER St. Louis, Mo.</p>		<p>NAME OF CHURCH St. Louis, Mo.</p>		<p>NAME OF CLERGYMAN St. Louis, Mo.</p>	
<p>NAME OF DECEASED'S HOME St. Louis, Mo.</p>		<p>NAME OF DECEASED'S BUSINESS St. Louis, Mo.</p>		<p>NAME OF DECEASED'S EMPLOYER St. Louis, Mo.</p>		<p>NAME OF DECEASED'S OCCUPATION St. Louis, Mo.</p>		<p>NAME OF DECEASED'S RESIDENCE St. Louis, Mo.</p>		<p>NAME OF DECEASED'S ADDRESS St. Louis, Mo.</p>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7428

## CERTIFICATE OF DEATH

Reg. Dist. No. 07424

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>OHIO</b> b. COUNTY <b>Lorraine</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>72 x - 3</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SACRED HEART HOSPITAL</b>				d. STREET ADDRESS <b>944 N. PASADENA AVE.</b>					
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>GARVIN</b> Last <b>MCGHEE</b>				4. DATE OF DEATH Month <b>JULY</b> Day <b>21</b> , Year <b>19 59.</b>					
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/15, -1889</b>			
9. AGE (In years last birthday) yrs. <b>69</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Heavy equipment operator/Construction Kilmarnock, Scotland</b>		11. BIRTHPLACE (State or foreign country) <b>U.S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>			
13. FATHER'S NAME <b>JAMES MCGHEE</b>				14. MOTHER'S MAIDEN NAME <b>Agnes? (Unknown)</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No,</b>				16. SOCIAL SECURITY NO. <b>282-03-6576</b>					
17. INFORMANT <b>Mrs. Clinton Mudge</b>				Address <b>944 N. Pasadena Ave., Elyria, Ohio</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>550.1</b> <b>Refluxed gangrene of stomach + generalized</b> DUE TO (b) <b>12 days</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Chronic Myocarditis</b>								INTERVAL BETWEEN ONSET AND DEATH <b>12 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b>19</b> Month <b>19</b> Day <b>19</b> Year <b>19</b> a. m. p. m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) <b>Twinsburg, Ohio</b>				20g. (County) (State)					
21. I certify that I attended the deceased from <b>July 11, 19 59</b> , to <b>July 21, 19 59</b> , that I last saw the deceased alive on <b>July 21, 19 59</b> , and that death occurred at <b>8:02 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>116 Greene St. Cumberland Md 21 7-22 59</b> DATE SIGNED <b>July 24 59</b>									
ACTUAL SIGNATURE <b>James T. Johnson Jr. M.D.</b>				PHYSICIAN'S NAME (Type) <b>James T. Johnson Jr. M.D.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>7/25/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Crown Hill Cemetery</b>			
22d. LOCATION (City, town, or county) <b>Twinsburg, Ohio</b>				(State)					
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Wayne George</b>				ADDRESS <b>Cumberland, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE July 24 59</b>			
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>									





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7429.

## CERTIFICATE OF DEATH

Reg. Dist. No.

07425

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>800 Trost Ave</b>		e. STREET ADDRESS <b>800 Trost Ave</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>June</b> Middle <b>Ann</b> Last <b>McKenzie</b>		4. DATE OF DEATH Month <b>July</b> Day <b>18</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 17 1947</b>
9. AGE (In years lost birthday) <b>11</b> yrs		IF UNDER 1 YEAR Months <b>11</b> Days <b>11</b> Hours <b>11</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Cumberland, Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Leonard A. McKenzie</b>		14. MOTHER'S MAIDEN NAME <b>Harriet Carolan</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Leonard A. McKenzie, Cumberland, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRAIN Tumor</b> 237X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 17, 1959</b> to <b>July 17, 1959</b> , that I last saw the deceased alive on <b>July 17, 1959</b> , and that death occurred at <b>12-22 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>43 Garrett Cumberland Md</b> DATE SIGNED <b>July 17, 1959</b> ACTUAL SIGNATURE <b>B. M. Schindler</b> M.D. PHYSICIAN'S NAME (Type) <b>B. M. Schindler</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 21 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Patricks Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Byron Kight</b>		ADDRESS <b>Cumberland, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>JUL 21 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krasa</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7430

## CERTIFICATE OF DEATH

Reg. Dist. No.

07426

1. PLACE OF DEATH a. COUNTY <b>Allegheny</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegheny</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>1yr; 11mo; 3wk.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sylvan Retreat</b>		e. STREET ADDRESS <b>16 Decatur Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Edith</b> Middle <b>Roberts</b> Last <b>Miller</b>		4. DATE OF DEATH Month <b>July</b> Day <b>4</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 2, 1884</b>
9. AGE (In years lost birthday) <b>74</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>4</b> Hours <b>19</b> Min. <b>59</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Christopher Roberts</b>		14. MOTHER'S MAIDEN NAME <b>Jane Boyns</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Elizabeth L Miller Cumberland, Maryland</b>	
17. INFORMANT <b>Elizabeth L Miller</b>		Address <b>Cumberland, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocardial Degeneration 422</b> 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>General arteriosclerosis 450</b> DUE TO (c) <b>Chronic nephritis 592</b> INTERVAL BETWEEN ONSET AND DEATH <b>?</b> <b>?</b> <b>?</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>304 Severe psychosis. -</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 11th 1959</b> to <b>July 4th 1959</b> , that I last saw the deceased alive on <b>July 3rd 1959</b> , and that death occurred at <b>11:56p.m.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>49 Greene St. -</b> DATE SIGNED ACTUAL SIGNATURE <b>James E. McLean</b> M.D. PHYSICIAN'S NAME (Type) <b>James E. McLean, M.D.</b> <b>49 Greene Street, Cumberland, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/7/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ruth E. Silcox</b>		ADDRESS <b>Cumberland Maryland</b>	
24a. REC'D BY REGISTRAR DATE <b>JUL 9 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hearn</b>	

11-28

MAINE BOARD

DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of informant		12. Signature of witness	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery	
16. Signature of health officer		17. Signature of coroner		18. Signature of jury	
19. Signature of jury		20. Signature of jury		21. Signature of jury	
22. Signature of jury		23. Signature of jury		24. Signature of jury	
25. Signature of jury		26. Signature of jury		27. Signature of jury	
28. Signature of jury		29. Signature of jury		30. Signature of jury	
31. Signature of jury		32. Signature of jury		33. Signature of jury	
34. Signature of jury		35. Signature of jury		36. Signature of jury	
37. Signature of jury		38. Signature of jury		39. Signature of jury	
40. Signature of jury		41. Signature of jury		42. Signature of jury	
43. Signature of jury		44. Signature of jury		45. Signature of jury	
46. Signature of jury		47. Signature of jury		48. Signature of jury	
49. Signature of jury		50. Signature of jury		51. Signature of jury	
52. Signature of jury		53. Signature of jury		54. Signature of jury	
55. Signature of jury		56. Signature of jury		57. Signature of jury	
58. Signature of jury		59. Signature of jury		60. Signature of jury	
61. Signature of jury		62. Signature of jury		63. Signature of jury	
64. Signature of jury		65. Signature of jury		66. Signature of jury	
67. Signature of jury		68. Signature of jury		69. Signature of jury	
70. Signature of jury		71. Signature of jury		72. Signature of jury	
73. Signature of jury		74. Signature of jury		75. Signature of jury	
76. Signature of jury		77. Signature of jury		78. Signature of jury	
79. Signature of jury		80. Signature of jury		81. Signature of jury	
82. Signature of jury		83. Signature of jury		84. Signature of jury	
85. Signature of jury		86. Signature of jury		87. Signature of jury	
88. Signature of jury		89. Signature of jury		90. Signature of jury	
91. Signature of jury		92. Signature of jury		93. Signature of jury	
94. Signature of jury		95. Signature of jury		96. Signature of jury	
97. Signature of jury		98. Signature of jury		99. Signature of jury	
100. Signature of jury		101. Signature of jury		102. Signature of jury	

1



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death.

VS. A15ME  
BM 2/57

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7431 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07427

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>	c. LENGTH OF STAY IN 1b <b>8 DAYS</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MT. SAVAGE</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SABRED HEART HOSPITAL</b>		d. STREET ADDRESS <b>MT. SAVAGE</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>W.</b> Last <b>NUSE</b>		4. DATE OF DEATH Month <b>JULY</b> Day <b>23</b> Year <b>1959</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 27, 1986</b>	
9. AGE (in years last birthday) <b>72</b> yrs.		10. UNDER 1 YEAR Months <b>2</b> Days <b>5</b>	11. UNDER 24 HRS. Hours <b>2</b> Min. <b>5</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self</b>		
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>PETER NUSE (DECEASED)</b>		14. MOTHER'S MAIDEN NAME <b>ANNIE BAKER (DECEASED)</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <b>220-10-1585</b>		
17. INFORMANT <b>PATIENTS CHART</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cardial Failure</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Chronic Myocarditis</b> [a], stating the underlying cause lost. DUE TO (c) <b>Coronary Occlusion, Left</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma of Pancreas</b>				
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE <b>Benedict Skitarellic</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <b>Benedict Skitarellic, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>July 23, 1959</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/25/59</b>		
22c. NAME OF CEMETERY OR CREMATORY <b>MT Savage Meth. Cem</b>		22d. LOCATION (City, town, or county) (State) <b>MT Savage Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Louis Stein Inc. Cumb. Md</b>		ADDRESS <b>MT Savage Md.</b>		
24a. REC'D BY REGISTRAR <b>DATE JUL 28 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		

07157

STATE DEPARTMENT OF HEALTH - BIRMINGHAM  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH	
JAMES EARL RAY		35		M		W		APR 4, 1968		10:00 PM		MEMPHIS, TENN.	
OCCUPATION		RESIDENCE		CAUSE OF DEATH		MANNER OF DEATH		DISEASES PREEXISTING		DISEASES ACQUIRED		DISEASES PRESENT	
ATTORNEY		MEMPHIS, TENN.		HEART DISEASE		SUICIDE		CORONARY ARTERY DISEASE		HYPERTENSION		MYOCARDIAL INFARCTION	
SIGNED		DATE		SIGNED		DATE		SIGNED		DATE		SIGNED	
JAMES EARL RAY		APR 4, 1968		JAMES EARL RAY		APR 4, 1968		JAMES EARL RAY		APR 4, 1968		JAMES EARL RAY	



7432

CERTIFICATE OF DEATH

07428

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>37 DAYS</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 CUMBERLAND, M</b>				d. STREET ADDRESS <b>519 PEARREE AVENUE</b>			
d. NAME OF HOSPITAL (If not in hospital, give place of death) <b>WARWICK &amp; MEMORIAL MEMORIAL HOSPITAL AVES.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ALVEY</b> Middle <b>B.</b> Last <b>O NEAL</b>				4. DATE OF DEATH Month <b>JULY</b> Day <b>1</b> Year <b>19 59</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>OCTOBER 25, 1870</b>	
9. AGE (In years birthday) <b>88</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Millworker</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Lumber Industry</b>		11. BIRTHPLACE (State or foreign country) <b>CUMBERLAND, MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>WILLIAM O NEAL</b>				14. MOTHER'S MAIDEN NAME <b>SARA MORGAN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>235-40-6760 A</b>			
17. INFORMANT <b>MEMORIAL HOSPITAL</b>				Address <b>CUMBERLAND, MARYLAND</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Failure</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio Sclerosis Heart Disease</b> DUE TO (c) <b>Arterio Sclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b> <b>Unknown</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>June 30</b> , 19 <b>57</b> , to <b>July 1</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>June 30</b> , 19 <b>57</b> , and that death occurred at <b>8:45 P.</b> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>519 July 59</b> DATE SIGNED ACTUAL SIGNATURE <b>DR. DAVID REES</b> M.D. PHYSICIAN'S NAME (Type) 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 22b. DATE THEREOF <b>7/4/59</b> 22c. NAME OF CEMETERY OR CREMATORY <b>Prosperity Cemetery</b> 22d. LOCATION (City, town, or county) (State) <b>Flintstone (Rural) Maryland</b> 23. FUNERAL DIRECTOR'S SIGNATURE <b>Ruth E. Silcox</b> ADDRESS <b>Cumberland Maryland</b> 24a. REC'D BY REGISTRAR <b>JUL 7 '59</b> 24b. REGISTRAR'S SIGNATURE <b>Carlton L. Hanes</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death.

M

5232

CERTIFICATE OF DEATH

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

7433

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>			c. LENGTH OF STAY IN 1b <b>40 Years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland, Md. 02</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sacred Heart Hospital, Decatur St.</b>				d. STREET ADDRESS <b>158 Bedford St. 1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>David</b> Middle <b>S.</b> Last <b>Palmer</b>				4. DATE OF DEATH Month <b>July</b> Day <b>20</b> Year <b>1959</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-5-76</b>		
9. AGE (In years lost birthday) yrs. <b>83</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.		IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired B&amp;O RR</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
13. FATHER'S NAME <b>Karney Palmer, (D)</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Seibert (D)</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Pt's. Chart</b> Address <b>from Nrs. Julia Palmer 158 Bedford St.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral embolus</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bronchiectasis</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>June 8, 1959</b> , to <b>July 20, 1959</b> , that I last saw the deceased alive on <b>July 20, 1959</b> , and that death occurred at <b>5:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>50 Pershing Street, Cumberland, Md.</b> DATE SIGNED <b>7/21/59</b>								
ACTUAL SIGNATURE <b>S. M. Jacobson</b>		PHYSICIAN'S NAME (Type) <b>S. M. Jacobson, M.D., 50 Pershing Street, Cumberland, Maryland</b>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/23/1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rosedale Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Martinsburg, W. Va.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Byron Knight</b> ADDRESS <b>Cumberland, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 23 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>		

10

— 100 —

• • •

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be used by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7434

CERTIFICATE OF DEATH

Reg. Dist. No.

07430

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland,</b>		c. LENGTH OF STAY IN 1b <b>02 Cumberland,</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>315 Pulaski St.,</b>		d. STREET ADDRESS <b>315 Pulaski St.,</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Thomas</b> Middle <b>Orville</b> Last <b>Rahrig</b>		4. DATE OF DEATH Month <b>July</b> Day <b>28</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 14, 1898</b>
9. AGE (In years last birthday) <b>60</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Celanese Corp.</b>	
11. BIRTHPLACE (State or foreign country) <b>Cumberland, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Matthew F. Rahrig</b>		14. MOTHER'S MAIDEN NAME <b>Mary O'Malley</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes, W.W.# 1</b>		16. SOCIAL SECURITY NO. <b>214-07-2136</b>	
17. INFORMANT <b>Mrs. Geraldine Rahrig</b>		Address <b>Cumberland, Md. 315 Pulaski St.,</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary artery disease</b> DUE TO (c) <b>1 hour 3 yrs</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 hour 3 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>19 56</b> to <b>7-28-19 59</b> that I last saw the deceased alive on <b>July 19 59</b> , and that death occurred at <b>8:15P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>16 Greene St.,</b> DATE SIGNED <b>James T. Johnson</b>			
ACTUAL SIGNATURE <b>James T. Johnson</b> M.D.		DATE SIGNED <b>16 Greene St.,</b>	
PHYSICIAN'S NAME (Type) <b>James T. Johnson M.D.</b>		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/31/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>SS. Peter &amp; Paul's</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Wayne George</b>		ADDRESS <b>Cumberland, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>AUG 3 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

# CERTIFICATE OF DEATH

**ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED**

DECEASED NAME LAST FIRST MIDDLE (Print or type full name)	
SEX MALE FEMALE	
AGE YEARS MONTHS DAYS (Print or type age at death)	
DATE OF DEATH MONTH DAY YEAR	
PLACE OF DEATH (Print or type place of death)	
CAUSE OF DEATH (Print or type cause of death)	
MANNER OF DEATH (Print or type manner of death)	
SIGNATURE OF DECEASED (If deceased was under 18 years of age, sign of parent or guardian)	
SIGNATURE OF WITNESSES (Print or type names of witnesses)	
SIGNATURE OF REGISTRAR (Print or type name of registrar)	
OFFICE OF THE REGISTRAR (Print or type office of registrar)	
COUNTY OF DEATH (Print or type county of death)	
STATE OF DEATH (Print or type state of death)	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

07431

7435

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. LENGTH OF STAY IN 1b <b>39 Hrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sacred Heart Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Harry</b> Middle <b>Lawson</b> Last <b>Reynolds</b>				4. DATE OF DEATH Month <b>July</b> Day <b>15</b> Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb 24, 1889</b>	
9. AGE (In years last birthday) <b>70</b>		IF UNDER 1 YEAR Months <b>70</b> Days <b>15</b> Hours <b>19</b> Min. <b>59</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B&amp;O R.R.</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Lawson Reynolds</b>		14. MOTHER'S MAIDEN NAME <b>Mary Benner</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>705-09-9935</b>		17. INFORMANT <b>Pt's chart.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Kidney Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Nephrosclerosis</b> DUE TO (c) <b>Arteriosclerotic Cardiovascular Renal Disease</b>							INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>unknown</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>13 July 1959</b> , to <b>7-15 1959</b> , that I last saw the deceased alive on <b>7/15 1959</b> , and that death occurred at <b>2:10 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>S. G. WEISMAN</b>				DATE SIGNED <b>7/16/59</b>			
PHYSICIAN'S NAME (Type) <b>S. G. WEISMAN M.D. CUMBERLAND MD.</b>				ADDRESS (Street, city or town, state) <b>59 GREENE ST</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/18/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Pleasant Grove Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland Maryland (Rural)</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ruth E. Silcox</b>				ADDRESS <b>Cumberland Maryland</b>		24a. REC'D BY REGISTRAR <b>JUL 20 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>C. E. Silcox</b>							

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be used by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

DATE OF DEPARTURE

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

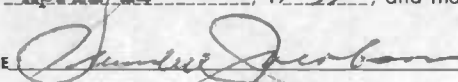
DATE OF DEATH

DATE OF DEATH

## CERTIFICATE OF DEATH

Reg. Dist. No.

07432

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>WEST VIRGINIA</b> b. COUNTY <b>MINERAL</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GREEN SPRING</b> 85X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVES.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>RUSSELL CHARLES RIGGS</b>		4. DATE OF DEATH Month Day Year <b>JULY 14 1959</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 4 1908</b>
9. AGE (In years last birthday) yrs. <b>51</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>3 14 00 00</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fire Fighter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Aircraft Corp.</b>	
11. BIRTHPLACE (State or foreign country) <b>ARKANSAS-JENNY LINN</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CHARLES RIGGS</b>		14. MOTHER'S MAIDEN NAME <b>IDA SEARVER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>yes WARII</b>		16. SOCIAL SECURITY NO. <b>705-09-3520</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL</b>		Address <b>CUMBERLAND, MARYLAND</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Anterior Myocardial Infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Arteriosclerosis</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>3 Yrs</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb. 1956</b> , to <b>April 14 1959</b> , that I last saw the deceased alive on <b>April 14 1959</b> , and that death occurred at <b>5:15 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE 		ADDRESS (Street, city or town, state) DATE SIGNED <b>50 Pershing Street 7/16/59</b>	
PHYSICIAN'S NAME (Type) <b>DR. S. M. JACOBSON</b>		<b>Cumberland, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 17, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Forest Glenn</b>		22d. LOCATION (City, town, or county) (State) <b>Greenspring, W. Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 20 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>C. L. S. H. H. H.</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

07-25-50



UNITED STATES DEPARTMENT OF JUSTICE

1950

THE COURT

WEST VIRGINIA

ALLIANCE

GREEN SMITH

1 DAY

HOSPITAL HOSPITAL

RIGHT

CHURCH

1950

1950

1950

1950

1950



1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

07433

24b. REGISTRAR'S SIGNATURE  
*Arthur J. Wright*

VS. AISME  
5M 2/57





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be filed with the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7454

## CERTIFICATE OF DEATH

Reg. Dist. No.

07434

1. PLACE OF DEATH o. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. LENGTH OF STAY IN 1b <b>Lifetime</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>22 Frostburg</b>		d. STREET ADDRESS <b>148 Ormand Street</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miners Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JEAN</b> Middle Last <b>ROWE</b>				4. DATE OF DEATH Month <b>7</b> Day <b>7</b> Year <b>19 59</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-10-1883</b>		9. AGE (In years last birthday) <b>76 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>Eonaconing</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Ralph Reed</b>				14. MOTHER'S MAIDEN NAME <b>Amanda Heider</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. James Rowe, 413 S. Anglesea St., Md.</b>		Address <b>Baltimore 24.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage - left</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Hypertension with Heart</b> DUE TO (c) <b>Revised 12 yrs?</b> INTERVAL BETWEEN ONSET AND DEATH <b>8 days</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>NONE</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7/1/59</b> , 19 <b>59</b> , to <b>7/7/59</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>7/7/59</b> , 19 <b>59</b> , and that death occurred at <b>1:45 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>48 Broadway</b> <b>7/8/59</b>							
ACTUAL SIGNATURE <b>M. M. Rothstein</b>		M.D. <b>48 Broadway</b>					
PHYSICIAN'S NAME (Type) <b>M. M. ROTHSTEIN M.D.</b>		<b>FROSTBURG - MD.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-9-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Frostburg Memorial Park, Frostburg</b>		22d. LOCATION (City, town, or county) (State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Benel H. Whitesell</b>				24a. REC'D BY REGISTRAR <b>Jul 13 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

3235

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled out by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7455

## CERTIFICATE OF DEATH

Reg. Dist. No.

07435

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b> <b>Allegany</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. LENGTH OF STAY IN 1b <b>30 yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miners Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>EDWARD</b> Last <b>SEVINSKY</b>		4. DATE OF DEATH Month <b>7</b> Day <b>21</b> Year <b>19 59</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-18-1895</b>
9. AGE (In years lost birthday) yrs. <b>64</b>		10. IF UNDER 1 YEAR Months <b>64</b> Days <b>1</b> Hours <b>19</b> Min.	11. IF UNDER 24 HRS. Months <b>64</b> Days <b>1</b> Hours <b>19</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Calander Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Kelly Springfield</b>	
11. BIRTHPLACE (State or foreign country) <b>Midland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Edward J. Sevinsky</b>		14. MOTHER'S MAIDEN NAME <b>Mary C. Stevenson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>214-01-6235</b>	
17. INFORMANT <b>James L. Sevinsky, 12 Hill Street,</b>		Address <b>Frostburg, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Heart disease</b> DUE TO (c) <b>Years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>21 July 19 59</b> , to <b>21 July 19 59</b> , that I last saw the deceased alive on <b>July 21, 19 59</b> , and that death occurred at <b>12:00 P.</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John B. Davis, M.D.</b>		ADDRESS (Street, city or town, state) <b>2 B BROADWAY</b>	
PHYSICIAN'S NAME (Type) <b>John B. DAVIS, M.D.</b>		DATE SIGNED <b>7/22/59.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7/24/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Michaels Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Frostburg Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Paul H. Montesant</b>		24a. REC'D BY REGISTRAR <b>JUL 27 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Paul H. Montesant</b>		24c. REGISTRAR'S SIGNATURE <b>Paul H. Montesant</b>	



## CERTIFICATE OF DEATH

Reg. Dist. No.

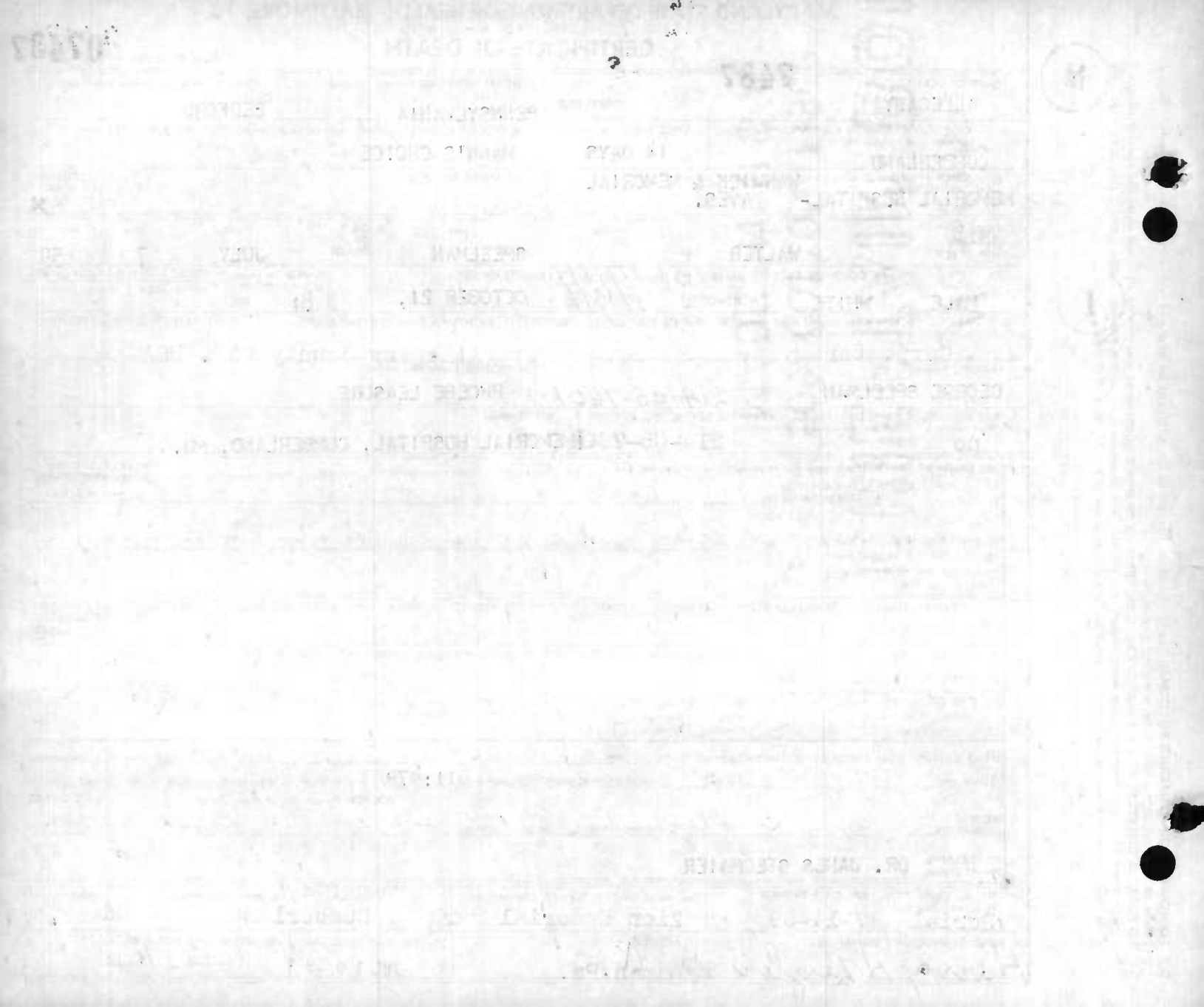
07437

7437

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>PENNSYLVANIA</b> b. COUNTY <b>BEDFORD</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>14 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, write address of institution) <b>WARRICK &amp; MEMORIAL HOSPITAL- AVES.</b>				d. STREET ADDRESS <b>75X-3</b>			
3. NAME OF DECEASED (Type or print) First <b>WALTER</b> Middle <b>SPEELMAN</b> Last <b>SPEELMAN</b>				4. DATE OF DEATH Month <b>JULY</b> Day <b>7</b> Year <b>1959</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		8. DATE OF BIRTH <b>OCTOBER 21, 1959</b>	
9. AGE (In years lost birthday) <b>81</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>19</b> Hours <b>59</b> Min.		IF UNDER 24 HRS. Months <b>7</b> Days <b>19</b> Hours <b>59</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <b>Allegany county Md.</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>GEORGE SPEELMAN</b>				14. MOTHER'S MAIDEN NAME <b>PHOEBE LEASURE</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>214-05-7601</b>			
17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cardiac Failure</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Atherosclerotic Cardiovascular Disease</b> DUE TO (c) <b>10 yrs</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>10 yrs</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>23 Jan, 1959</b> , to <b>7 July, 1959</b> , that I last saw the deceased alive on <b>7 July, 1959</b> , and that death occurred at <b>11:47 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>122 So Centre St, Cumberland Md</b> DATE SIGNED <b>8 July 59</b>							
ACTUAL SIGNATURE <b>James C. Stegmaier</b> M.D.							
PHYSICIAN'S NAME (Type) <b>DR. JAMES STEGMAIER</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-11-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Zion Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harvey H. Ziegler</b> ADDRESS <b>Hyndman, Pa.</b>				24a. REC'D BY REGISTRAR <b>JUL 10 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7438

## CERTIFICATE OF DEATH

Reg. Dist. No.

07438

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>02</b> years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		d. STREET ADDRESS <b>1110 Frederick Street</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1110 Frederick Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Oscar</b> Middle <b>Ervin</b> Last <b>Steinla</b>		4. DATE OF DEATH Month <b>July</b> Day <b>2</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 17, 1890</b>
9. AGE (In years last birthday) yrs. <b>69</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Own Business</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steinla Motor Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Finzel, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Jacob Steinla</b>		14. MOTHER'S MAIDEN NAME <b>Mary Werner</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-05-7833</b>	
17. INFORMANT <b>1110 Frederick Street</b> <b>Mrs. Mernie Steinla Cumberland, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease with coro-</b> <b>420.0</b> DUE TO <b>nary insufficiency and terminal arrest</b> seconds (b) <b>Right Pulmonary Infarct &amp; abscess with</b> DUE TO <b>draining bronchopleural fistula</b> 3 weeks (c) <b>Carcinoma of the Stomach</b> 3 months PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Nat white at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>October 10, 19 58</b> to <b>July 2nd, 1959</b> , that I last saw the deceased alive on <b>July 1st, 19 59</b> , and that death occurred at <b>8:10 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>July 3, 1959</b>			
ACTUAL SIGNATURE <b>Wyand P. Doerner</b> M.D.			
PHYSICIAN'S NAME (Type) <b>Wyand P. Doerner M.D. Algonquin Hotel, Cumberland, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7/5/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>	22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 7 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Curtis L. Hanna</b>	



FOR STATE  
HEALTH DEPT.

7439 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07439

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>02 Cumberland</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>511 Valley Street</b>		d. STREET ADDRESS <b>511 Valley Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>Young</b> Last <b>Sturtz</b>		4. DATE OF DEATH Month <b>July</b> Day <b>26</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 26, 1884</b>
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months <b>75</b> Days <b>00</b> Hours <b>00</b> Min. <b>00</b>	IF UNDER 24 HRS. Months <b>00</b> Days <b>00</b> Hours <b>00</b> Min. <b>00</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework Own Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Lonaconing, MD.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Daniel Young</b>		14. MOTHER'S MAIDEN NAME <b>Agnes McMillian</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>17. INFORMANT</b> <b>Mrs Walter Harris</b> Address <b>Cumberland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary hemorrhage</b> 292.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Aplastic Anemia</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>"Sister"</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs</b> <b>2 yrs.</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Benedict Skitaralic</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Benedict Skitaralic</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/29/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Lonaconing Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>GEORGE EICHHORN</b>		ADDRESS <b>LONACONING, MD.</b>	
24a. REC'D BY REGISTRAR <b>DATE Jul 28 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is reported, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Albany

Albany

Albany

Albany

Albany

Albany

Albany

Albany

Albany

Albany

Albany

Albany

Albany

Albany

Albany

Albany

Albany

Albany

Albany

Albany

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7440

CERTIFICATE OF DEATH

Reg. Dist. No.

07440

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>6 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SACRED HEART HOSPITAL</b>				d. STREET ADDRESS <b>216 CENTRAL AVE.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>KATHRYN</b> Middle <b>SUDER</b> Last				4. DATE OF DEATH <b>July 31, 1959</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov 11, 1895</b>	
9. AGE (In years last birthday) <b>63</b>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Grafton, Maryland, W. Va.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Joseph D. Newham</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Payne Creel</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>MRS. VIRGINA DUNLAP</b> Address <b>Green St, Cumberland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma R. Kidney</b> <b>180x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinomatous</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>3 mths</b> <b>3 wks</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>July 25, 1959</b> to <b>July 31, 1959</b> , that I last saw the deceased alive on <b>July 30, 1959</b> , and that death occurred at <b>2:55 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Clay Durrett</b> M.D.				ADDRESS (Street, city or town, state) <b>236 Virginia Ave., Cumberland, Md.</b> DATE SIGNED <b>5/2/59</b>			
PHYSICIAN'S NAME (Type) <b>CLAY DURRETT, M.D.</b>				<b>236 VIRGINIA AVE., CUMBERLAND, MD.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug. 2, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b> ADDRESS				24a. REC'D BY REGISTRAR <b>AUG 5 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knease</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7441 CERTIFICATE OF DEATH

Reg. Dist. No.

07441

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>18yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>944 Glenwood St.</u>				d. STREET ADDRESS <u>944 Glenwood St</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Stanley Swauger</u>				4. DATE OF DEATH Month Day Year <u>7-4-1959</u>			
5. SEX <u>W</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 25, 1903</u>		9. AGE (In years last birthday) <u>56</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accessories &amp; Repair Rubber Tire Mfg. Ellerslie, Pa.</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
13. FATHER'S NAME <u>Wm. F. Swauger</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Kelly</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <u>213-03-0855</u>		17. INFORMANT Address <u>Bruce F. Swauger Cumberland, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Pancreas</u> 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Hour a. m. _____ p. m. _____ Month _____ Day _____ Year <u>1959</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____				20g. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>8/3/59</u> 19____, to <u>7/4/59</u> 19____, that I last saw the deceased alive on <u>6/25/59</u> 19____, and that death occurred at <u>5:15A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard J. Williams</u> M.D.				ADDRESS (Street, city or town, state) <u>Cumberland</u> DATE SIGNED <u>7/6/59</u>			
PHYSICIAN'S NAME (Type) <u>Richard J. Williams 122 S. Centre St. Cumberland, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-6-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lybarger Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Madley, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli</u> ADDRESS <u>Cumberland, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 8 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be used by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7442 CERTIFICATE OF DEATH

Reg. Dist. No.

07442

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>6/27/59</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Allegany County Infirmary</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Lula</b> Middle <b>Elizabeth</b> Last <b>Tucker</b>		4. DATE OF DEATH Month <b>July</b> Day <b>1</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/1/1876</b>
9. AGE (In years last birthday) <b>82</b>		10. IF UNDER 1 YEAR: Months <b>1</b> Days <b>19</b> Hours <b>59</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Keyser, West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Mason Samuel Tucker</b>		14. MOTHER'S MAIDEN NAME <b>Rachel McNemar</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>Allegany County Infirmary Records</b>	
17. INFORMANT <b>P.O.Box 599</b> Address <b>Cumberland, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocardial Degeneration</b> 154X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <b>General Arteriosclerosis, -</b> DUE TO (c) <b>Rectal Carcinoma, -</b> INTERVAL BETWEEN ONSET AND DEATH <b>?</b> <b>?</b> <b>?</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Nephritis</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6/27/59</b> , 19 <b>7/1/59</b> , that I last saw the deceased alive on <b>6/30/59</b> , 19 <b>7/1/59</b> , and that death occurred at <b>10:05 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>49 Greene St. Cumberland, Md.</b> DATE SIGNED <b>7/1/59</b>			
ACTUAL SIGNATURE <b>James E. McLean</b> M.D.		PHYSICIAN'S NAME (Type) <b>Dr. James E. McLean</b> <b>Cumberland, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/3/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 6 59</b>	
24b. REGISTRAR'S SIGNATURE <b>William L. Haug</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be used by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Marital Status		Occupation		Cause of Death		Date of Death		Place of Death		Signature of Physician		Signature of Registrar	
Maryland		65		Male		White		Married		Farmer		Heart Disease		July 1968		Baltimore, Md.		[Signature]		[Signature]	
County		Baltimore		Male		White		Married		Farmer		Heart Disease		July 1968		Baltimore, Md.		[Signature]		[Signature]	
Name of Deceased		Age		Sex		Race		Marital Status		Occupation		Cause of Death		Date of Death		Place of Death		Signature of Physician		Signature of Registrar	
Maryland		65		Male		White		Married		Farmer		Heart Disease		July 1968		Baltimore, Md.		[Signature]		[Signature]	
County		Baltimore		Male		White		Married		Farmer		Heart Disease		July 1968		Baltimore, Md.		[Signature]		[Signature]	

## 7399 CERTIFICATE OF DEATH

Reg. Dist. No.

07388

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>1 1/2 HOURS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL WARWICK &amp; MEMORIAL AVES.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>BOBIE</b> , Middle <b>Z.</b> , Last <b>TRUE</b>				4. DATE OF DEATH Month <b>JULY</b> Day <b>26</b> Year <b>1959</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MAY 27</b>	
9. AGE (In years last birthday) yrs. <b>60</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>CUMBERLAND, MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				13. FATHER'S NAME <b>JOSEPH METZ</b>			
14. MOTHER'S MAIDEN NAME <b>DEEMA, ROBINETTE</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Congestive Heart Failure</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic Myocarditis - Hypertension Arterio</b> sclerosis (c) <b>Myocardial Infarction</b>							INTERVAL BETWEEN ONSET AND DEATH <b>6 hours</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>July 19, 1959</b> , to <b>July 26, 1959</b> , that I lost the deceased alive on <b>July 26, 1959</b> , and that death occurred at <b>9:55 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Dr. Overton Himmelwright</b>				ADDRESS (Street, city or town, state) <b>133 W. Ave. Cumberland, Md.</b>			
DATE SIGNED <b>7/27/59</b>				PHYSICIAN'S NAME (Type) <b>DR. OVERTON HIMMELWRIGHT</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/29/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Willcrest Burial Pl.</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Louis Allen Inc.</b>				ADDRESS <b>Cumb. Md.</b>		24a. REC'D BY REGISTRAR <b>DATE JUL 31 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kenna</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

07338

CERTIFICATE OF DEATH

1339

DATE

DECEASED

DECEASED

DECEASED

15 HOURS

DECEASED

WARRICK A. WARRICK

WARRICK A. WARRICK

113 NORTH BROADWAY

THE

POST

WARRICK

WHITE

WARRICK

WARRICK A. WARRICK

WARRICK A. WARRICK

WARRICK A. WARRICK

WARRICK A. WARRICK





## 7443 CERTIFICATE OF DEATH

Reg. Dist. No.

07443

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>WEST VIRGINIA</b> b. COUNTY <b>MINERAL</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WILEY FORD</b> 85x-3			
c. LENGTH OF STAY IN TB <b>16 DAYS</b>				d. STREET ADDRESS <b>State St.,</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL, MEMORIAL &amp; WARWICK AVES.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>RUTH</b> Middle <b>Esther</b> Last <b>TYSINGER</b>				4. DATE OF DEATH Month <b>JULY</b> Day <b>19</b> Year <b>19 59</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>SEPT. 17, 1897</b>	
9. AGE (In years last birthday) <b>61</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>Mt. Jackson, Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>ISAAC FRYE</b>				14. MOTHER'S MAIDEN NAME <b>REBECCA BAKER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No,</b>				16. SOCIAL SECURITY NO. <b>None</b>			
17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Rubeus Erythematosis</b> 705.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>2-3</b> 19 <b>58</b> , to <b>7-19-1959</b> that I last saw the deceased alive on <b>7-19-1959</b> , and that death occurred at <b>11:07 PM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Cumberland Md</b> DATE SIGNED <b>7-20-59</b>							
ACTUAL SIGNATURE <b>W. F. Williams</b> M.D.							
PHYSICIAN'S NAME (Type) <b>DR. W. F. WILLIAMS.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/22/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Zion Memorial Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b>				ADDRESS <b>Cumberland, Md.</b>		24a. REC'D BY REGISTRAR <b>JUL 22 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur E. Evans</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100

STATE OF NEW YORK

IN SENATE

January 10, 1901

REPORT

OF THE

COMMISSIONERS OF THE LAND OFFICE

1900

1901

1902

1903

1904

1905

1906

1907

1908

1909

1910

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7444

## CERTIFICATE OF DEATH

Reg. Dist. No.

07444

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			c. LENGTH OF STAY IN 1b <b>1 DAY</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 CUMBERLAND</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SACRED HEART HOSPITAL</b>				d. STREET ADDRESS <b>1 210 PACA ST.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>EULA</b> Middle <b>Frances</b> Last <b>VANSANT</b>				4. DATE OF DEATH Month <b>JULY</b> Day <b>1</b> Year <b>19 59</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 5, 1920</b>	
9. AGE (In years last birthday) <b>39</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer in twisting</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Celanese Corp.</b>		11. BIRTHPLACE (State or foreign country) <b>Harding, W. Va.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Floyd Bennett</b>				14. MOTHER'S MAIDEN NAME <b>Maud Poling</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No,</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>215-20-6084</b>		17. INFORMANT <b>Mr. Thomas F. VanSant</b> Address <b>Cumb. Md. 210 Paca St.;</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Myocardial Infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Artery Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetic Mellitus - Severe, Multiple Renal Abscess</b>						INTERVAL BETWEEN ONSET AND DEATH <b>30 min</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>June 19 58</b> to <b>7-1</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>7-1</b> , 19 <b>59</b> , and that death occurred at <b>12:55A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>William P. James</b> M.D. <b>4411 Centre St</b> <b>7-2-59</b> PHYSICIAN'S NAME (Type) <b>WILLIAM P. JAMES, M.D.</b> <b>N. CENTRE ST., CUMBERLAND, MD.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/3/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Herman Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Wayne George</b> ADDRESS <b>Cumberland, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 6 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton S. Knaus</b>	

CERTIFICATE OF DEATH

1911

1912

1913

1914

1915

1916

1917

1918

1919

1920

1921

1922

1923

1924

1925

1926

1927

1928

1929

1930

1931

1932

1933

1934

1935

1936

1937

1938

1939

1940

1941

1942

1943

1944

1945

1946

1947

1948

1949

1950

1951

1952

1953

1954

1955

1956

1957

1958

1959

1960

1961

1962

1963

1964

1965

1966

1967

1968

1969

1970

1971

1972

1973

1974

1975

1976

1977

1978

1979

1980

1981

1982

1983

1984

1985

1986

1987

1988

1989

1990

1991

1992

1993

1994

1995

1996

1997

1998

1999

2000

2001

2002

2003

2004

2005

2006

2007

2008

2009

2010

2011

2012

2013

2014

2015

2016

2017

2018

2019

2020

2021

2022

2023

2024

2025

2026

2027

2028

2029

2030

2031

2032

2033

2034

2035

2036

2037

2038

2039

2040

2041

2042

2043

2044

2045

2046

2047

2048

2049

2050

2051

2052

2053

2054

2055

2056

2057

2058

2059

2060

2061

2062

2063

2064

2065

2066

2067

2068

2069

2070

2071

2072

2073

2074

2075

2076

2077

2078

2079

2080

2081

2082

2083

2084

2085

2086

2087

2088

2089

2090

2091

2092

2093

2094

2095

2096

2097

2098

2099

2100

2101

2102

2103

2104

2105

2106

2107

2108

2109

2110

2111

2112

2113

2114

2115

2116

2117

2118

2119

2120

2121

2122

2123

2124

2125

2126

2127

2128

2129

2130

2131

2132

2133

2134

2135

2136

2137

2138

2139

2140

2141

2142

2143

2144

2145

2146

2147

2148

2149

2150

2151

2152

2153

2154

2155

2156

2157

2158

2159

2160

2161

2162

2163

2164

2165

2166

2167

2168

2169

2170

2171

2172

2173

2174

2175

2176

2177

2178

2179

2180

2181

2182

2183

2184

2185

2186

2187

2188

2189

2190

2191

2192

2193

2194

2195

2196

2197

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be used by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7456

## CERTIFICATE OF DEATH

07445

Reg. Dist. No.

1. PLACE OF DEATH <b>Allegany</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <b>Adolph-John-Waitekunas</b>		MARYLAND		a. STATE <b>Md</b>		b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westernport</b>		c. LENGTH OF STAY IN Ib <b>60 Yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>43 Westernport</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>103 First St.</b>				d. STREET ADDRESS <b>103 First St</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Adolph</b> Middle <b>Joseph</b> Last <b>Waitekunas</b>				4. DATE OF DEATH Month <b>July</b> Day <b>20</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct 4, 1883</b>		9. AGE (In years last birthday) <b>75</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Paper Mill</b>		11. BIRTHPLACE (State or foreign country) <b>Lithuania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Adam Waitekunas</b>				14. MOTHER'S MAIDEN NAME <b>Not Known</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>Mrs. A. J. Waitekunas-Westernport</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) <b>arteriosclerosis</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>6 hrs</b> <b>5 yrs</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 1, 1954</b> to <b>July 20, 1959</b> , that I last saw the deceased alive on <b>July 20, 1959</b> , and that death occurred at <b>6:4 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Piedmont W. Va</b> DATE SIGNED <b>P. E. Berry</b> ACTUAL SIGNATURE <b>P. E. Berry</b> M.D. <b>Piedmont W. Va</b> PHYSICIAN'S NAME (Type) <b>P. E. Berry</b> <b>Piedmont W. Va</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>7/23/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Peters</b>		22d. LOCATION (City, town, or county) (State) <b>Westernport Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>E. S. Boal</b>				ADDRESS <b>Westernport, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 22 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Colman S. Kraus</b>			





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7445

CERTIFICATE OF DEATH

07446

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>4/29/58</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Allegany County Infirmary</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>Ashton</b> Last <b>Ward</b>		4. DATE OF DEATH Month <b>July</b> Day <b>4</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/14/1905</b>
9. AGE (In years last birthday) <b>53</b> yrs		10. IF UNDER 1 YEAR Months <b>53</b> Days <b>53</b> Hours <b>53</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - Iron Construction Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Eglon, West Virginia</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Robert Charles Ward</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Rummer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>382 09 0073</b>	
17. INFORMANT <b>P.O.Box 599</b>		Address <b>Cumberland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO <b>422.2</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral arteriosclerosis</b> DUE TO <b>Chronic Myocarditis</b> (c) <b>Chronic Myocarditis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>?</b> <b>?</b> <b>?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Rh. Hemiplegia</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>19</b> o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4/29/58</b> , 19 <b>7/4/59</b> , to <b>7/4/59</b> , 19 <b>7/4/59</b> , that I last saw the deceased alive on <b>7/4/59</b> , 19 <b>7/4/59</b> , and that death occurred at <b>7:15P</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James E. McLean</b> M.D.		ADDRESS (Street, city or town, state) <b>49 Greene St.</b> DATE SIGNED <b>7/6/59</b>	
PHYSICIAN'S NAME (Type) <b>Dr. James E. McLean</b>		<b>Cumberland, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7/7/1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rest Lawn Gardens</b>	22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Byron Knight</b>		ADDRESS <b>Cumberland, Md.</b>	
24a. REC'D BY REGISTRAR <b>JUL 8 1959</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

# CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BALTIMORE, MD.

149 North Street

149 North Street

July

Word

Robert

Robert

Robert - from pneumonia, worked in the U.S. Navy

Robert - from pneumonia

Robert - from pneumonia

Robert - from pneumonia

Robert - from pneumonia

Robert - from pneumonia

Robert - from pneumonia

Robert - from pneumonia

Robert - from pneumonia

Robert - from pneumonia

Robert - from pneumonia

Robert - from pneumonia

Robert - from pneumonia

Robert - from pneumonia

Robert - from pneumonia

Robert - from pneumonia

Robert - from pneumonia

Robert - from pneumonia

Robert - from pneumonia

Robert - from pneumonia

Robert - from pneumonia

Robert - from pneumonia

Robert - from pneumonia

Robert - from pneumonia

Robert - from pneumonia

Robert - from pneumonia

Robert - from pneumonia

Robert - from pneumonia

Robert - from pneumonia

Robert - from pneumonia

Robert - from pneumonia

Robert - from pneumonia

Robert - from pneumonia

Robert - from pneumonia

Robert - from pneumonia

Robert - from pneumonia

Robert - from pneumonia

Robert - from pneumonia

Robert - from pneumonia

Robert - from pneumonia

Robert - from pneumonia

7446  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>8 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVES.</b>				e. STREET ADDRESS <b>303 WASHINGTON STREET</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>HELEN</b> Middle <b>WELLINGTON</b> Last <b>WELLINGTON</b>				4. DATE OF DEATH Month <b>JULY</b> Day <b>30</b> Year <b>1959</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>NOV 20</b>	
9. AGE (In years lost birthday) yrs. <b>80</b>		IF UNDER 1 YEAR Months <b>12</b> Days <b>30</b> Hours <b>30</b> Min. <b>15</b>		IF UNDER 24 HRS. Hours <b>30</b> Min. <b>15</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>W. W. WILEY</b>				14. MOTHER'S MAIDEN NAME <b>LILLIAN OGIBY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes, give war or dates of service				16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>MEMORIAL HOSPITAL CUMBERLAND, MARYLAND</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal heart failure</b> <b>420.0</b> DUE TO <b>arteriosclerotic &amp; hypertensive</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>heart disease</b> (c) <b>3 years</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. <b>19</b> Month, Day, Year				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>1955</b> , 19____, to <b>30 July</b> , 1959 that I last saw the deceased alive on <b>30 July</b> , 1959, and that death occurred at <b>3:10 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>122 S. Center St</b> DATE SIGNED <b>31 July 59</b>							
ACTUAL SIGNATURE <b>Dr. Alfred Van Ormer</b> M.D.				PHYSICIAN'S NAME (Type) <b>DR. W. A. VAN ORMER</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>Aug 1, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	
22d. LOCATION (City, town, or county) (State) <b>Cumberland Md.</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>Louis Stein, Inc. Cumberland Md.</b>				24a. REC'D BY REGISTRAR <b>AUG 3 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7446

ALLEGANY

MARYLAND

ALLEGANY

6 DAYS

CUMBERLAND

303 WASHINGTON STREET

MEMORIAL HOSPITAL

WETTINGTON

HELEN

20

WHITE

RENIE

WETTINGTON

ELLIAN GARY

W. M. WILEY

CUMBERLAND, MARYLAND

MEMORIAL HOSPITAL

## 7447 CERTIFICATE OF DEATH

Reg. Dist. No. 07448

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>W.VA.</b> b. COUNTY <b>PRESTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>2 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>		d. STREET ADDRESS <b>113 CALDWELL STREET</b>	
3. NAME OF DECEASED (Type or print) First <b>ASA</b> Middle <b>F.</b> Last <b>WILHELM</b>		4. DATE OF DEATH Month <b>JULY</b> Day <b>2</b> Year <b>1959</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEBRUARY 6,</b>
9. AGE (In years last birthday) <b>72</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED - MAIL CLERK</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>TERRA ALTA, W.VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>XXX JOHN WILHELM</b>		14. MOTHER'S MAIDEN NAME <b>MARTHA CRAMER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma Squamous</b> <b>1533</b> DUE TO <b>Bow perforated bowl and</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>peritonitis</b> (c) <b>48 hrs</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Not determined</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Cumberland, W. Va.</b>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7/1/59</b> , 19, to <b>7/2/59</b> , 19, that I last saw the deceased alive on <b>7/1/59</b> , 19, and that death occurred at <b>12:50 AM</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Cumberland, W. Va.</b> DATE SIGNED <b>7/3/59</b>	
ACTUAL SIGNATURE <b>DR. R.J. WILLIAMS</b>		PHYSICIAN'S NAME (Type)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>JULY 4, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>TERRA ALTA CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>TERRA ALTA, WEST VIRGINIA</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>P.R. Watson</b> ADDRESS <b>Terra Alta, W. Va.</b>		24a. REC'D BY REGISTRAR <b>JUL 10 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEATH CERTIFICATE

RESIDENT

N.Y.

ALBANY

CHURCH

5 DAYS

YERBA ALTA

113 CALLE DEL REY

MEMORIAL HOSPITAL

AGE

WILHELM

JULY 2

FEBRUARY 2

WHITE

MALE

RETIRED - MAIL CARRIER

YERBA ALTA, N.Y.

WINTER DRUMMER

JOHN WILLIAMS

MEMORIAL HOSPITAL - ALBANY, N.Y.

*John Williams*  
*Retired Mail Carrier*  
*Yerba Alta, N.Y.*

DR. R. W. WILLIAMS

JULY 4 1959 YERBA ALTA CHURCH

YERBA ALTA, NEW YORK



## 7448 CERTIFICATE OF DEATH

07449

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>ALLEGANY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>11 DAYS</b>			
d. NAME OF HOSPITAL (If not hospital, give street address) <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVES.</b>				d. STREET ADDRESS <b>1113 BRADDOCK ROAD</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>MINNIE</b> Middle <b>Belle</b> Last <b>WRIGHT</b>				4. DATE OF DEATH Month <b>JULY</b> Day <b>2</b> Year <b>1959</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>AUG. 14, 1882</b>	
9. AGE (In years lost birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>PARRAN HEAVENER</b>				14. MOTHER'S MAIDEN NAME <b>ELLA, GOINGS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>			
INFORMANT <b>MEMORIAL HOSPITAL</b>				Address <b>CUMBERLAND, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia</b> <b>454X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Bangrene - both lower extremities</b> DUE TO (c) <b>arterio thrombosis, complete</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>2 day</b> <b>2 day</b> <b>2 day</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Congestive heart failure - arteriovascular heart disease</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>May 31</b> , 19 <b>59</b> , to <b>July 2</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>July 2</b> , 19 <b>59</b> , and that death occurred at <b>6:25 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Algonquin Hotel, Cumberland, Md</b> DATE SIGNED <b>7/4/59</b>							
ACTUAL SIGNATURE <b>Thomas F. Lewis</b> M.D.							
PHYSICIAN'S NAME (Type) <b>DR. THOMAS LEWIS M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 5, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland.</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 13 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death.

VS A15 (4)  
15M 9/58

STATE OF NEW YORK  
CERTIFICATE OF DEATH

ALLEGEDLY  
CURRENTLY  
11 DAYS  
CEREMONY

1113 BRADDOCK ROAD  
HONOLULU 2, HAWAII

MINUTE  
BIRTH  
JULY  
FEMALE  
WHITE

U.S.A.  
LAST VISITING  
Honolulu

ELLY, CONNOR  
PARRAY KEVNER

GENERAL HOSPITAL  
HONOLULU, HI

*[Faint, illegible text, likely a signature or official statement]*

*[Faint, illegible text, likely a signature or official statement]*

10. YEARS LIVING  
John A. ...  
...